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THE **JOURNAL** OF THE **ARKANSAS** MEDICAL SOCIETY

Volume 87 Number 1

June, 1990

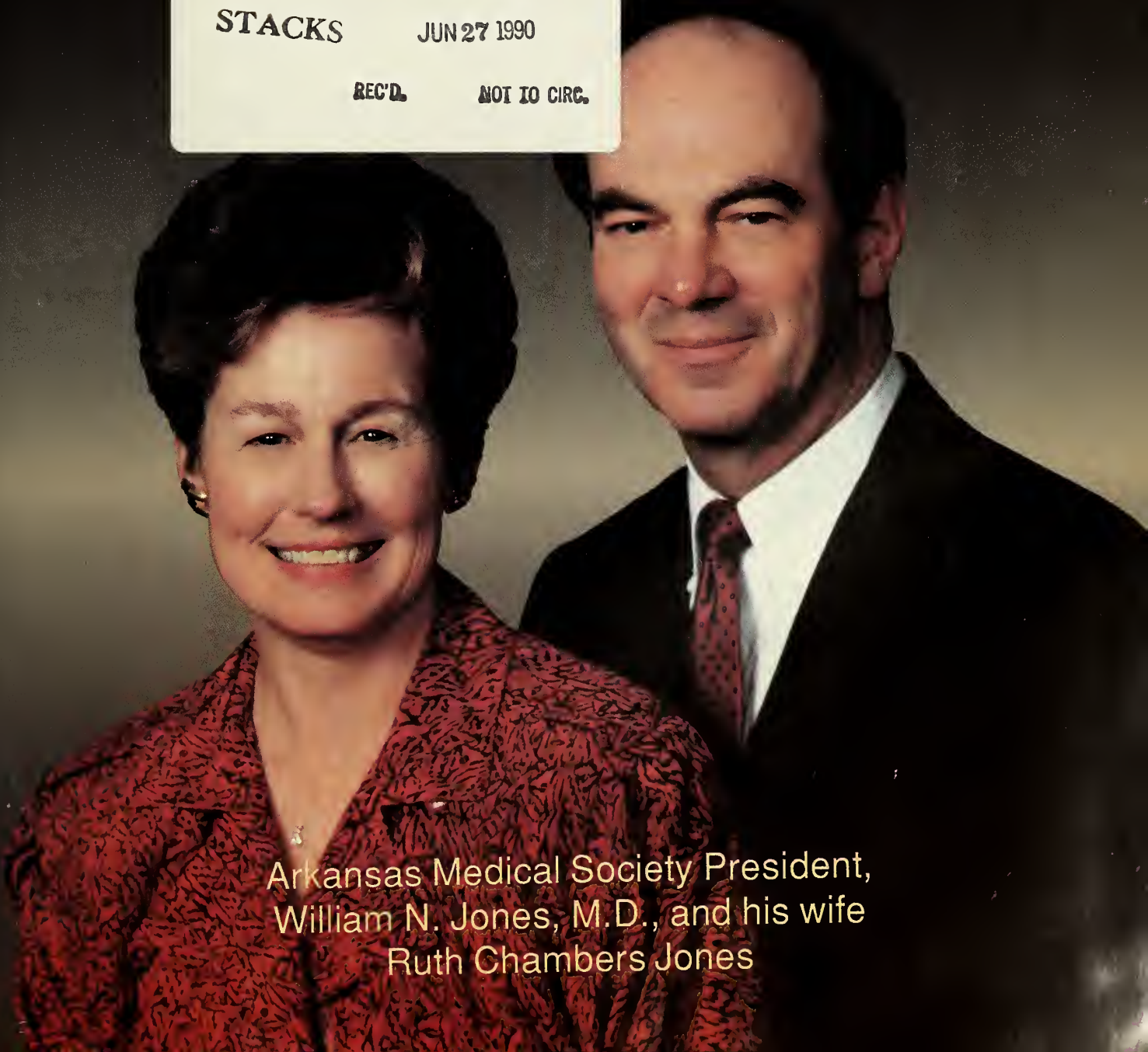
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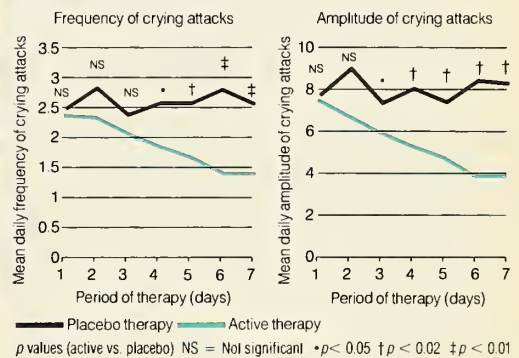
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The first page should list titles, degrees, and any hospital or university appointments of the author(s). Manuscripts should be typewritten, double-spaced, and have generous margins. The original and one copy should be submitted. Pages should be numbered. Manuscripts are not returned; however, original photographs or drawings will be returned upon request after publication. Manuscripts should be no longer than ten typewritten pages. Exceptions will be made only under most unusual circumstances.

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References should be limited to ten; if more than ten are listed, the author(s) may designate the ten most significant to be printed and readers will be referred to the authors(s) for the complete list. References must contain, in the order given: Name of author(s), title of article, name of periodicals with volume, page, month and year. References should be numbered consecutively in the order in which they appear in the text.

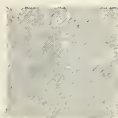
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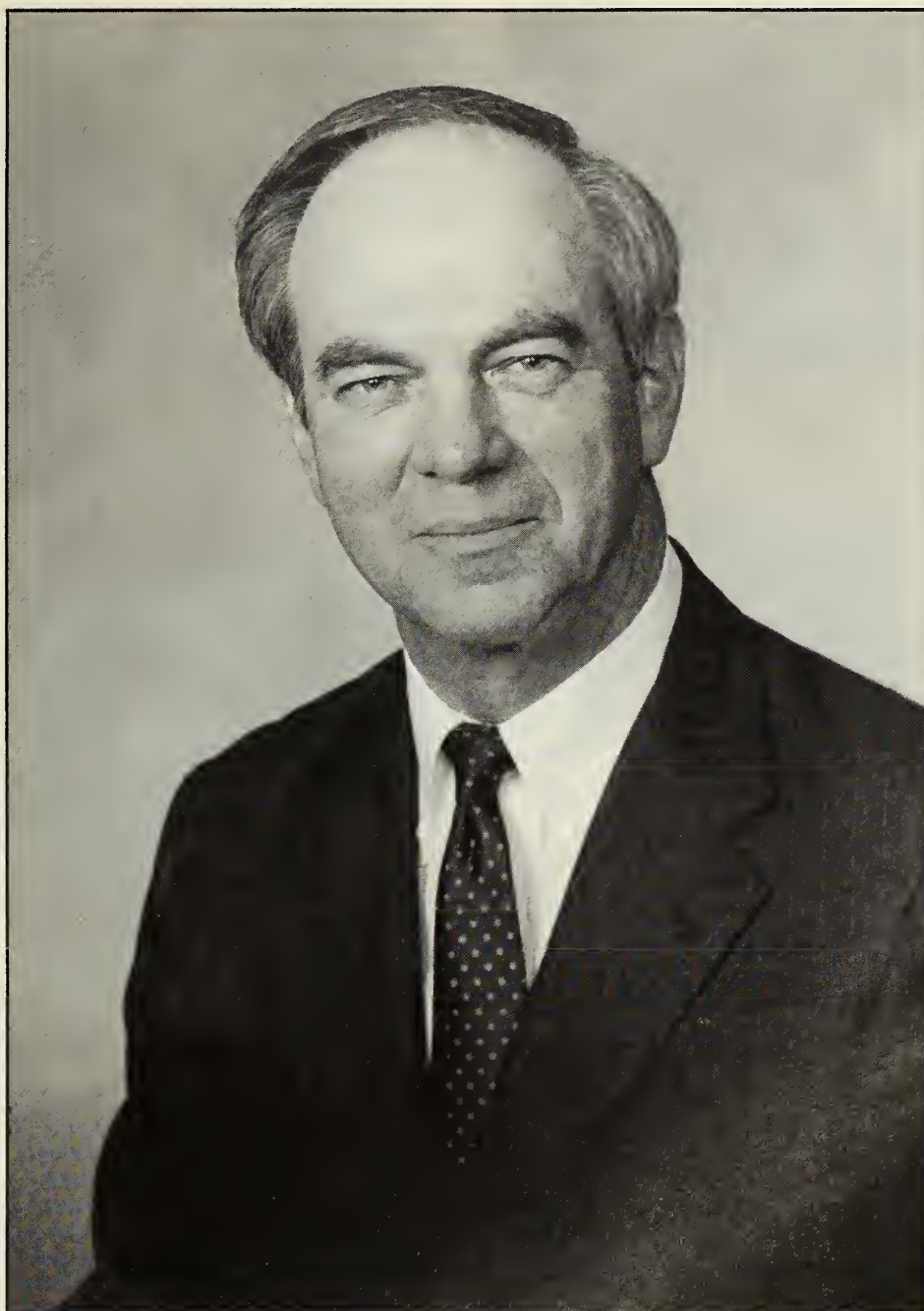
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William N. Jones, M.D.
President
Arkansas Medical Society
1990-1991
Little Rock, Arkansas





Inaugural Address

William N. Jones, M.D.
President
1990-1991

Dr. Weber, ladies and gentlemen: Tonight I want to make some observations about the state of the Arkansas Medical Society as we enter the 1990's, present a few thoughts about the national scene, and touch on three goals for our immediate future.

The State of the Arkansas Medical Society

As I stand before you tonight, I am pleased to tell you the Arkansas Medical Society is in excellent health as we enter the 1990's. Oh yes, we still have an occasional upper respiratory infection or a pain in our sacroiliac but nothing we cannot immediately restore to normal physiology. The Arkansas Medical Society has fully recovered from past illnesses involving the budget, the employees' pension plan, and the location of its home office and related staff matters. The Society has acquired new vigor and has leaped forward for its members and the public they serve. Even so, the Society must continue to stay fine tuned, alert, diligent and practice good stewardship of all our resources. We must constantly be seeking answers to the problems that confront us and our patients. We must anticipate and be prepared with alternatives and solutions to those problems and not just sit back and react to proposals from outside the medical community.

It is time for us to revise our Constitution and Bylaws making them more relevant to today and our progressive society. We must continue to nurture, encourage, inform and involve our membership in all of our activities.

So what is the Arkansas Medical Society doing in this regard? What is right about the Arkansas Medical Society?

First, there is the Arkansas Medical Society Auxiliary. Long before I ever heard of the Arkansas Medical Society, I was aware of the "Auxiliary." I feel sure that Mona Lawson and my mom, Rosina, must have started the modern day

Auxiliary. I used to hear about it when Mona paid me a penny a day to help her make her bed. The Auxiliary has a long history of accomplishments that complement our work. Look at the Auxiliary today. Currently it is in the midst of one of its most ambitious projects in a program directed at teenage drinking and driving. At this time, I would like to recognize the newly elected president of the Auxiliary, Jo Ann Williams, of Russellville. Mrs. Williams, would you please stand and receive our applause. And now would you please show your appreciation to Past Presidents Nikki Lawson and Sara Jouett, who have chaired the DWI Teenage Project. The Arkansas Medical Society Auxiliary is right about the Arkansas Medical Society.

The excellent, conscientious, capable and supportive staff led by Ken LaMastus is right about the Arkansas Medical Society.

The location and the high profile building which houses our office are right about the Arkansas Medical Society.

The new enthusiastic Governmental Affairs Department headed by Lynn Zeno and the excitement and involvement he generates in our membership for things political is right about the Arkansas Medical Society.

The actions of the Executive Committee, the Council, the House of Delegates, and the increased participation in the business of the American Medical Association by our AMA delegates are right about the Arkansas Medical Society.

The outreach programs such as the Indigent Care Program providing access to care for those less fortunate, the Committee on AIDS responding to the challenges of the HIV epidemic, our volunteerism and our speakers bureau are right about the Arkansas Medical Society.

Our liaison with the Arkansas Department of Health, the Arkansas Foundation for Medical Care, the Arkansas Association of Retired Persons, the University of Arkansas for Medical Sciences, Arkansas Blue Cross & Blue Shield, and

the Arkansas Department of Human Services are right about the Arkansas Medical Society.

Our support of medical students and house staff organizations and our Medical Education Foundation for Arkansas are right about the Arkansas Medical Society.

Our growing membership, our Long Range Plan, which is rapidly being implemented and not a document catching dust, and our Physicians' Health Committee are right about the Arkansas Medical Society.

Our Journal, newsletters, legislative updates and other publications, our legal counsel, our line item budget, and our reasonable and affordable employees pension plan are right about the Arkansas Medical Society.

And finally, the relevancy of our annual sessions like the one we are completing tonight are right about the Arkansas Medical Society.

Yes, the state of the Arkansas Medical Society is excellent. So, we will keep our heads up, our eyes straight ahead, and as Admiral Farragut admonished at the Battle of Mobile Bay, "Damn the torpedoes, full speed ahead," bring on the 1990's.

The National Scene

On the national scene, we will see many changes in the 1990's. Change is inevitable, but we must ensure that the changes are in the best interest of the medical profession and the patients we serve. The health care system in the United States is the finest in the world. Someone once said, "It takes a carpenter to build a barn but any old jackass can kick it down." We must not allow our health care system to be destroyed by those who would opt for something less.

Many point to the Canadian system as a potential health delivery system for the United States. Where do Canadians go for health care they cannot receive in their country? When government takes over health care, quality of care and medical research are decreased and rationing and long lines are the result.

Our profession must seek an affordable plan to help provide access to health care for over 37 million persons currently without this protection.

At the national level, as in Arkansas, we must develop alternatives and present programs and not sit back and react to others ideas. Negotiation with prudence and reason will be required to protect all those involved.

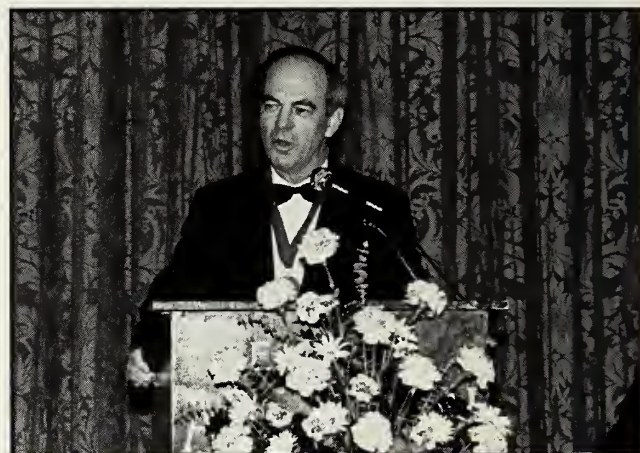
There is no doubt that the technologies we have today have exceeded the ability of society to pay for the care that is available. This is one of the major problems we face. Society would provide everyone with food, shelter and medical care. It is alright for the food to be beans, bread and beer purchased with food stamps; and as long as the shelter does not leak, never mind the holes in the sheetrock and the broken window panes. But alas, the medical care has to be the state of the art in technology. Therein lies the problem we face.

The Oregon Plan that would allocate resources - ration-

ing perhaps a better term - we have heard about at this meeting. The American Medical Association has no position on the Oregon Plan at this time, but I am sure it will receive debate in the June meeting of the AMA House of Delegates.

A few weeks ago, the American Medical Association presented its program Health Access America, a 16 point plan to restructure and strengthen the United States health care system. It's primary goals are to reduce health care cost and ensure that all Americans have access to health care.

At a recent AMA Leadership Conference held in Phoenix, I listened to a presentation on the Resource Based



Relative Value Scale. I can tell you the RBRVS is not worked out yet. One economist even suggested, at its best, it will fail and be scrapped in a few years. I can assure you, there is no consensus on many aspects of the plan, but it will be implemented as Congress has ordained.

In other sessions, speaker after speaker addressed subjects such as managed care, practice parameters, data bank, and medicare volume performance standards. I thought of the two persons about whom all this is being directed. There sits the caring compassionate physician at the side of his patient in need, and they are both totally vulnerable, completely oblivious and essentially helpless as the social scientists and bureaucratic experts scrutinize that relationship with the social equivalent of the electron microscope.

There are no easy answers but we must maintain our high standards and stay involved for the preservation of the doctor/patient relationship. To do otherwise invites further erosion of that relationship.

The good news is that things could be worse. We could have expenditure targets, in-office DRG's and a capitation system. Organized medicine has been at work and will continue to work.

We all get tired of listening to some of our colleagues cry foul and criticize the AMA and the AMS for what they perceive as not defending their turf. Those persons are part of the problem and we must get them involved in the solution.

An old Tennessee mountain sage once said there are three kinds of people. There are them that make things happen. There are them that watches things happen. And there are them that wants to know when it is all over - what the hell happened! We have to have less of the "what the hell's" and more of the "make it happen's."

How can we reasonably be critical of the system if we don't participate? I would like all of the physicians in the room to stand and pair off. Now hear this! The most revered and treasured privilege in a democracy is the right of the individual to vote. You cannot vote if you are not registered. Now I want you to look into each other's faces. Unless something has changed radically since a 1984 survey of the members of the Arkansas Medical Society, only one of you is currently registered to vote. The other one is not participating and therefore is part of our problem. The last day to register to vote in the May 29 election is just three days away - May 8. Please take care of this matter the first thing Monday morning. You may be seated!

The complexities of the practice of medicine and the delivery of medical care have never been greater. The total of the advances in the last 100 years will be dwarfed by the new technologies of the next decade. The best is yet to come. It is an exciting and challenging time to serve humankind.

Goal for Our Immediate Future

Last fall, in preparation for my year as president, I had several meetings with the staff. At one of those sessions, Ken pointed out it was customary for the president to have a theme or target for his year. I really thought he would have been content to let this be a status-quo or let the sleeping dogs lie type of year, particularly after all of the hell I have raised in this society! Well, as Ken sat there smoking his cigarette, violating the Arkansas Medical Society's resolution on smoking, I saw my target! Ken's target is to quit smoking by December 31, 1990! He didn't choose it - I did!

So here is the message, "A Counterblast to Tobacco," by King James I of England, 1604:

"A custom loathsome to the eye, hateful to the nose, harmful to the brain, dangerous to the lungs, and in the black, stinking fume thereof, nearest resembling the horrible Stygian smoke of the pit that is bottomless.

Herein is not only a great vanity, but a great contempt of God's good gifts, that the sweetness of man's breath, being a good gift of God, should be willfully corrupted by this stinking smoke."

At our annual session in 1987, we passed a resolution on AIDS that resulted in the formation of the Committee on AIDS and our education efforts on HIV disease. Many of you will remember we also passed a resolution on smoking. Smoking is responsible for more than 390,000 premature deaths in this country each year.

It is past time for us to give smoking and tobacco products our attention. To this end, I am appointing Dr. David Rogers, chairperson of our new Committee on Smoking and Tobacco Products. David and I have discussed some broad objectives of this new committee. The program will include a seminar entitled, "How To Help Your Patient Stop Smoking," conducted by a special faculty from the National Cancer Institute. David and I are excited about the potential of this committee.

A second goal will be the implementation in Arkansas of the program initiated by the American Bar Association and the American Medical Association entitled, "ABA/AMA - A New Kind of Partnership Against Drug and Alcohol Abuse." This involves a team composed of a lawyer and a physician going into the classroom to carry on a dialogue with students about the legal and medical consequences of abuse of these substances. The president of the Arkansas Bar Association, Mr. David Glover, and I have discussed the program and we plan to start our "Arkansas Partnership" next month.

Since I became a Councilor in 1978, I have sought support for a mechanism whereby younger persons in our society can assume positions of leadership early in their careers. They should not have to wait for some tragedy to



befall a colleague to have an opportunity for leadership. The revisions in our Constitution and Bylaws, discussed at this meeting, would provide them opportunities. The following statement made by a surgeon, who on his 70th birthday was being honored by the American College of Surgeons, is relevant to this issue.

"As I watch older men coming down the ladder
As down they must come,
With younger men passing them
As pass they must to go up,
It so often has been an unhappy time for both.
The older man is not always able to see the necessity

Or perhaps the justice of his descent,
 And resents his slipping from the position that he has
 held,
 Instead of gently and peacefully helping this passing
 By assisting the younger man.
 What pleasure and comfort I have had
 From my hours with younger men.
 They still have their imagination, their vision,
 And the future is bright before them.
 Each day as I go through the hospital
 Surrounded by younger men,
 They give me of their dreams,
 And I give them of my experience,
 And I get the better of the exchange."

we stood. Suddenly the lady interrupted saying, "Aren't you little Billy Jones from Benton?" Surprised I answered yes and she continued, "I used to take you fishing down to the river." For some time after that, those residents on occasions would remind me that I was just "little Billy Jones from Benton."

We should keep this in mind. We are all just little somebodies from somewhere. So is everybody else we hold in awe and wonderment at all levels of the society in which we live. We all can, and must, make a contribution. The system works but we must be willing to work the system.

I had written this part of my speech several weeks before Lynn Zeno called me and said we were invited to Washington, D.C., to testify about AIDS legislation before the Sub-



I solicit your support for the proposed revisions in the Constitution and Bylaws, revisions that assure many of the objectives of the Long Range Plan as we enter the last decade of this century.

Ruthie says many events in my life are contrived by persons seeking to keep me humble. Recently, I had the honor of having my name and my article about the American Medical Association's Policy on AIDS read into the Congressional Record. A close friend reminded me that the names of the Watergate conspirators are in that same record!

Probably nothing can be more humbling than to be reminded of our childhood. Several years ago, I was making teaching ward rounds with the dermatology residents, dutifully pointing out inadequacies in their knowledge about the malady suffered by the 85-year-old black lady by whose bed

committee on Health and the Environment. My first response was negative, and then I realized I wanted to practice what I preach.

All of us who have taken on the responsibility of leadership from time to time have been critical about some aspect of the AMA and AMS. It behooves us to change what we perceive as wrong or poor policy because, like it or not, Congress and our state legislature look to those bodies for advice and direction in matters that concern the public health and how medicine is, and will be, practiced.

In closing, I want to thank you for the honor and privilege of serving you as president. It is a responsibility for which I feel prepared, and I promise you, on my honor, I will do my best.

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1990 Arkansas Medical Society Annual Session

House of Delegates Composition

First Session: May 3 - Second Session: May 4

	<u>Officers</u>	<u>First Session</u>	<u>Second Session</u>
Speaker	John Crenshaw	present	present
Vice Speaker	Kelsy J. Caplinger III	present	present
President	James R. Weber	present	present
President-elect	William N. Jones	present	present
1st Vice President	Michael N. Moody	present	present
2nd Vice President	Joe H. Stallings Jr.	present	present
3rd Vice President	Brenda Powell	-	-
Secretary	Charles H. Rodgers	present	present
Treasurer	James M. Kolb Jr.	present	present

	<u>Councilors</u>	<u>First Session</u>	<u>Second Session</u>
District 1:	J. Larry Lawson	present	present
	Merrill J. Osborne	present	present
District 2:	John E. Bell	present	-
	Jim E. Lytle	present	-
District 3:	L. J. P. Bell	present	present
	Hoy B. Speer, Jr.	present	present
District 4:	Paul A. Wallick	present	present
	Lloyd G. Langston	present	present
District 5:	Cal R. Sanders	present	present
	Wayne G. Elliott	present	-
District 6:	James D. Armstrong	present	present
	F.E. Joyce	-	-
District 7:	Ronald J. Bracken	present	present
	Thomas H. Hollis	present	present
District 8:	Glen Baker	-	-
	David Barclay	-	-
	Paul Cornell	-	-
	Warren Douglas	-	-
	Charles Logan	present	present
	R. Jerry Mann	present	present
	Harold Purdy	present	present
District 9:	Robert H. Langston	present	present
	David L. Rogers	present	present
District 10:	Morton C. Wilson	present	present
	Gerald A. Stolz	present	present
	A. C. Bradford	present	present

	<u>Past Presidents</u>	<u>First Session</u>	<u>Second Session</u>
1979-1980	A. E. Andrews	present	present
1971-1972	C. Stanley Applegate	present	-
1985-1986	John P. Burge	-	present
1983-1984	Asa A. Crow	present	present
1964-1965	C. Randolph Ellis	-	present
1969-1970	Ross E. Fowler	present	present
1951-1952	Charles R. Henry Sr.	-	-
1982-1983	Morris M. Henry	present	-
1988-1989	John M. Hestir	present	present
1987-1988	W. Ray Jouett	present	present
1976-1977	Albert S. Koenig Jr.	present	present
1977-1978	W. Payton Kolb	present	present
1980-1981	Kemal E. Kutait	present	-
1986-1987	Ken Lilly	-	-
1967-1968	Joseph A. Norton	-	-
1974-1975	Ben N. Saltzman	present	present
1981-1982	Purcell Smith Jr.	present	-
1968-1969	H.W. Thomas	-	-
1975-1976	T. E. Townsend	present	present
1963-1964	Joe Verser	-	-
1972-1973	Robert Watson	-	-
1984-1985	Charles F. Wilkins Jr.	present	present
1973-1974	John P. Wood	-	-
1978-1979	George F. Wynne	present	-

	<u>Delegate</u>	<u>First Session</u>	<u>Second Session</u>
Arkansas (1)	Dennis B. Yelvington	present	present
Ashley (1)	D. L. Toon	-	-
Baxter (1)	Robert L. Baker	present	present
Benton (3)	William T. Summerlin	present	-
	Stephen L. Goss	-	present
Boone (1)	John T. Troupe	present	present
Bradley (1)	Joe H. Wharton	-	present
	George F. Wynne	present	-
Carroll (1)	NOT REPRESENTED	-	-
Chicot (1)	Danny T. Berry	-	-
Clark (1)	Noland H. Hagood	present	present
Cleburne (1)	J. Warren Murry	present	-
Columbia (1)	H. Scott McMahan	-	-
Conway (1)	NOT REPRESENTED	-	-
Craighead/ Poinsett (5)	Ben Owens	present	-
	Robert D. Frey	present	present
	David Pyle	present	-
	Joe H. Stallings, Jr.	present	present
	Don B. Vollman, Jr.	present	present
Crawford (1)	NOT REPRESENTED	-	-
Crittenden (1)	Steve P. Schoettle	present	present
Cross (1)	James T. Beaton	-	-
Dallas (1)	Hugh Nutt	-	-
Desha (1)	Guy U. Robinson	-	-
Drew (1)	NOT REPRESENTED	-	-
Faulkner (1)	J. J. Magie	present	present
Franklin (1)	David L. Gibbons	-	present
Garland (5)	Ronald J. Bracken	present	present
	J. Richard Gardial	-	-
	Doane M. Newton	present	present
	Eugene M. Shelby	present	present
	James L. Gardner	-	-
Grant (1)	NOT REPRESENTED	-	-
Greene/ Clay (1)	Roger Cagle	-	present
Hempstead (1)	Jim McKenzie	-	present
Hot Spring (1)	C.R. Ellis	-	present
Howard/ Pike (1)	Robert R. Sykes	-	-
Independence(1)	Lloyd G. Bess	present	present
Jackson (1)	NOT REPRESENTED	-	-
Jefferson (4)	Lee A. Forestiere	present	-
	Kenneth A. Martin	-	-
	Simmie Armstrong, Jr.	-	-
	Anna T. Ridling	present	present
Johnson (1)	Don Pennington	-	-
Lafayette (1)	Sanford E. Hutson	present	present
Lawrence (1)	Ralph F. Joseph	-	-
Lee (1)	NOT REPRESENTED	-	-
Little River (1)	Robert D. Dalby	-	-
Logan (1)	John R. Williams	-	-
Lonoke (1)	Jerry C. Chapman	-	-
Miller (3)	John A. Gillean	-	-
	Donald L. Duncan	-	-
	Herbert B. Wren	present	-
Mississippi (1)	Joseph V. Jones	-	present
Monroe (1)	Neylon C. David	present	present
Nevada (1)	H. Blake Crow	-	-
Ouachita (1)	William D. Dedman	-	present
Phillips (1)	L. J. P. Bell	present	present
Polk (1)	John H. Finck	present	present

Professional help for health professionals.

	<u>Delegate</u>	<u>First Session</u>	<u>Second Session</u>
Pope (2)	Frank Lawrence	present	-
	Michael F. Bell	-	present
Pulaski (28)	Durwood B. Allen, Jr.	-	-
	Carlos A. Araoz	-	present
	Raymond V. Biondo	-	present
	Warren C. Boop, Jr.	-	-
	Curry B. Bradburn, Jr.	-	-
	Scott H. Brown	-	-
	Kelsy J. Caplinger, III	present	present
	Gilbert O. Dean	present	present
	Marlon Doucet	-	-
	Charles P. Fitzgerald	-	-
	Gene L. France	-	-
	James L. Hagler	-	-
	Edwin Hankins, III	-	-
	James Headstream	-	present
	Fred O. Henker, III	-	-
	Charles R. Henry, Sr.	-	-
	Fred J. Kittler	-	-
	Marvin Leibovich	-	-
	J. Mayne Parker	present	present
	John D. Pike	-	-
	John F. Redman	-	present
	Charles H. Rodgers	present	present
	Ashley S. Ross, Jr.	-	-
	Ben N. Saltzman	-	present
	Bruce E. Schratz	-	-
	Robert F. Shannon	present	present
	Frank M. Sipes	-	present
	Robert Valentine, Jr.	-	-
Randolph (1)	Albert L. Baltz	-	-
Saline (1)	Marvin N. Kirk, Jr.	present	present
Sebastian (8)	R. Cole Goodman, Jr.	-	-
	A. Samuel Koenig, III	-	-
	John R. Lange	present	-
	Andre J. Nolewajka	-	-
	McDonald Poe, Jr.	-	-
	William H. Schemel	present	present
	John R. Swicegood	-	-
	Carl L. Williams	present	-
	J. David Busby	-	present
Sevier (1)	NOT REPRESENTED	-	-
St. Francis (1)	Samual A. McGuire	-	present
Tri-County (1)	Michael Moody	present	present
Union (2)	Wayne Elliott	present	-
	Bert Dougherty	-	present
Van Buren (1)	John A. Hall	-	-
Washington (5)	Anthony N. Hui	-	present
	Danny L. Proffitt	present	-
	David L. Rogers	present	present
	Joe P. Rouse	-	present
	Janet L. Titus	present	present
White (2)	Kenneth R. Meacham	present	present
	Daniel S. Davidson	-	-
Woodruff (1)	James E. Rowe	-	-
Yell (1)	James L. Maupin	present	present
Resident Physician			
Section (1)	David M. Halinski	present	-
Medical Student			
Section (1)	John Gaston	present	present

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Proceedings of the House of Delegates of the Arkansas Medical Society Hot Springs, Arkansas May 3-5, 1990

First Session - Thursday, May 3, 1990



Speaker of the House, John Crenshaw, called the House of Delegates to order at 5:00 p.m., on Thursday, May 3, 1990, at the 114th meeting of the Arkansas Medical Society's Annual Session. He called upon Kelsy Caplinger to give the invocation.

The colors were presented by the Arkansas National Guard, followed by a welcome from the mayor of Hot Springs, Melinda Baran.

Speaker Crenshaw introduced the following guests and asked each to come to the podium and address the House: Mrs. William C. Tippens Jr., Southern Regional vice president, American Medical Association; Mrs. J. Larry Lawson, president, Arkansas Medical Society Auxiliary; and Mrs. David Williams, president-elect, Arkansas Medical Society Auxiliary.

Speeches from the
First House of Delegates
begin on page 40.

The Speaker announced the House did have a quorum present and called for a motion from the floor to approve the minutes of the 113th House of Delegates as printed in the

June 1989 issue of the *Journal of the Arkansas Medical Society*. The motion passed.

Speaker Crenshaw asked President Weber to come forward and assist Mrs. Larry Lawson in presenting the American Medical Association Education and Research Fund (AMERF) checks to I. Dodd Wilson, M.D., dean of the UAMS. The first check, in the amount of \$4,734.00, is intended for the pursuit of excellence in the medical school's program, there are no restrictions on the use of the money. The second check, in the amount of \$17,360.39, is restricted to the school's program of financial assistance for medical students. Dr. Wilson thanked the Auxiliary and the Society for their work and explained how last year's monies were used.

Speaker Crenshaw announced three items of business that had been received in the Society office at least 20 days prior to the Annual Session but after the cutoff date for the printing of the convention issue of the *Journal*. (These items are printed immediately following the minutes of the First House of Delegates.) The business is as follows: resolution from the Arkansas Medical Society Medical Student Section concerning a scholarship fund; resolution from the Sebastian County Medical Society in memory of Edward J. Safranek, M.D.; and a resolution from the Tri-County Medical Society concerning outreach surgery.

Speaker Crenshaw announced that for new business to be introduced from the floor, two-thirds consent from those in attendance would be required. He asked if there was new business to be presented. There being none, he announced the vacancy which will occur in the Arkansas State Medical Board member-at-large position and the second and fourth congressional position of the Arkansas State Board of Health. Ray Jouett, M.D., of Little Rock, is currently serving in the member-at-large position of the Arkansas State Medical Board and is eligible for reappointment. Kenneth Meacham, M.D., of Searcy, is currently serving as the second congressional district representative and Wayne Elliott, M.D., of El Dorado, is serving as the fourth congressional district representative of the Arkansas State Board of Health. Both are eligible for reappointment.

Speaker Crenshaw announced the new Nominating Committee appointments as: District #2: Michael Moody, M.D., Salem; District #4: Lee Forestiere, M.D., Pine Bluff; District #6: James Armstrong, M.D., Ashdown; District #8: Charles Logan, M.D., Little Rock; and District #10: William Galloway, M.D., Russellville.

Speaker Crenshaw asked the present Nominating Committee to meet immediately following the House of Delegates to select a nomination for the member-at-large position of the Arkansas State Medical Board. He also asked the 1990-91 Nominating Committee to meet to elect a chairman and secretary.

Nominations from both the State Medical Board and the Arkansas State Board of Health are to be reported to the Society staff prior to the final House of Delegates.

There being no further business, the House adjourned until Saturday, May 5th.

Late Resolutions

Resolution from the Arkansas Medical Society Medical Student Section Concerning an Arkansas Medical Society Scholarship Fund

Whereas, the cost of obtaining a medical education continues to rise, and

Whereas, the average medical student graduates with a debt of over forty thousand dollars, and

Whereas, the Arkansas Medical Society Medical Student Section would like to increase the visibility of the Arkansas Medical Society on campus, therefore be it

Resolved, that the Arkansas Medical Society explore the possibility of establishing a scholarship fund to be controlled by either the Arkansas Medical Society or an appropriate foundation.

Resolution from the Tri-County Medical Society Concerning Outreach Surgery

Whereas, outreach surgery is a valuable service for patients living at a distance from surgical centers that would make travel to such centers a hardship, and

Whereas, outreach surgery is an important service that may be offered by rural hospitals and is important for their economic survival, and

Whereas, outreach surgery combines surgical care by a physician with an increased level of specialization and pre- and post-operative care by physicians most familiar with the patient's history and medical problems, thereby offers the best of both worlds and is thus a means of delivering the highest quality of care, therefore be it

Resolved, that the Tri-County Medical Society urges the Arkansas Medical Society to support the continued use of outreach surgery and oppose any effort to restrict the delivery of care by outreach surgery by administrative or regulatory action.

Resolution from the Sebastian County Medical Society In Memory of Edward J. Safranek, M.D.

Whereas, God in His infinite mercy has seen fit to call from our midst, Edward J. Safranek, M.D., and

Whereas, Dr. Safranek has faithfully served his patients in the community at-large throughout his entire medical

career, and

Whereas, Dr. Safranek, during his years of practice has reflected the highest ideals of his profession, and

Whereas, in his devotion to family, church, and friends, he exemplified the best in man, and

Whereas, the Sebastian County Medical Society mourns his loss, therefore be it

Resolved, by the Sebastian County Medical Society, in its regular meeting on March 13, 1990, hereby adopts this resolution and directs that a copy be spread on the minutes of the Society, a copy furnished to the family, and a copy published in the *Journal of the Arkansas Medical Society*.

Final Session - May 5, 1990



Speaker of the House, John Crenshaw, called the meeting to order at 4:15 p.m., Saturday, May 5, 1990, and gave the invocation.

Delegates seated from the floor were C. R. Ellis, Hot Spring County; James Headstream, Pulaski County; and J. David Busby, Sebastian County.

Speaker Crenshaw recognized Nominating Committee Chairman, Charles Logan, M.D., and asked him to come forward to present the 1990-91 slate of officers.

Dr. Logan read the following slate of officers:

President-elect:

George W. Warren, M.D., Smackover

Charles F. Wilkins Jr., M.D., Russellville

First Vice President:

Michael N. Moody, M.D., Salem

Second Vice President:

Linda A. Markland, M.D., Fayetteville

Third Vice President:

J. Warren Murry, M.D., Heber Springs

Treasurer:

James M. Kolb, Jr., M.D., Russellville

Secretary:

Charles H. Rodgers, M.D., Little Rock

Speaker of the House:

John Crenshaw, M.D., Pine Bluff

Vice Speaker of the House:

Kelsy J. Caplinger, III, M.D., Little Rock

Delegates to the AMA (1/1/91 - 12/31/92):

John P. Burge, M.D., Lake Village

A. E. Andrews, M.D., Texarkana

Alternate Delegates to the AMA (1/1/91 - 12/31/92):

David L. Rogers, M.D., Fayetteville

John M. Hestir, M.D., DeWitt

Councilors:

District 1: J. Larry Lawson, M.D., Paragould

District 2: John E. Bell, M.D., Searcy

District 3: L. J. P. Bell, M.D., Helena

District 4: Paul A. Wallick, M.D., Monticello

District 5: Cal R. Sanders, M.D., Camden

District 6: James D. Armstrong, M.D., Ashdown

District 7: Ronald J. Bracken, M.D., Hot Springs

District 8: David Barclay, M.D., Little Rock

R. Jerry Mann, M.D., Little Rock

Harold D. Purdy, M.D., Little Rock

District 9: Robert H. Langston, M.D., Harrison

District 10: Gerald A. Stolz, Jr., M.D., Russellville

Morton C. Wilson, M.D., Fort Smith

Charles F. Wilkins, Jr., M.D., asked to be recognized and to have his name removed from the slate. George Warren, M.D., was elected president-elect by acclamation. Charles Wilkins escorted Dr. Warren to the podium to give the following address:

Address by George Warren, M.D.

AMS President-Elect

Mr. Speaker, I want to take this opportunity to thank Drs. Logan, Moody and other members of the Nominating Committee for giving me this opportunity to continue to serve the Arkansas Medical Society and organized medicine.

I appreciate this House of Delegates of which I was a member for many years, for allowing me to become your president-elect. I will use this as a learning year to work with my peers on the Executive Committee and to work for the members of the Society. I would like to express one personal concern that I have noted throughout this meeting. Dr. McAfee, in his speech, spoke of a man who lost a leg who,

through good intentions, things went wrong. Instead of suing the doctor, he thanked him because he had shown an interest and because he cared. Dr. Weber mentioned a decline in some professional liability rates and professional liability suits. There have been other indications. Mr. Cisneros mentioned, he had a child born with congenital heart disease and thought that nothing could be done. Later he determined through a doctor who cared, something could be done to possibly arrange for that child to live. What I am trying to point out is that we are our patients' advocates.

We have been concerned about tort reform. If we can't get tort reform then I beg you to let's reform that which causes tort. Let's be our patients' advocates. Let's create in our patients goodwill. A few years ago we were number one in the line of people who were trusted and loved. We fell from that spot. Let's get back that spot which is truly ours.

I look forward to the opportunity to serve the Arkansas Medical Society.

Nominations for other positions as proposed by the Nominating Committee were also elected by acclamation.

Speaker Crenshaw asked Don Vollman, M.D., to come forward to introduce our guest speaker, Joycelyn Elders, M.D., director of the Arkansas Department of Health. Dr. Elders speech begins on page 45.

The next order of business was the reports from the Reference Committees.



Report of Reference Committee #1



Janet Titus, M.D., Winslow, Chairman
David Pyle, M.D., Jonesboro
Gene L. France, M.D., Little Rock
Dennis B. Yelvington, M.D., Stuttgart
Ron McGaugh, Little Rock, medical student observer

Resolution from the Young Physicians Committee Concerning Disability and Health Insurance Protection for Health Care Workers with AIDS (as amended)

Whereas, AIDS is unquestionably one of the greatest health concerns facing both patients and physicians, and

Whereas, there is a growing concern within the medical profession in regard to the accurate documentation and subsequent care of HIV infected health care workers, and

Whereas, the ability of HIV positive health care workers to practice their profession is unquestionably jeopardized; therefore be it

Resolved, that the Arkansas Medical Society's Committee on AIDS investigate the policies and responsibilities of health and disability insurance companies as they relate to HIV infection, and further be it

Resolved, that the Committee on AIDS continue to investigate whether hospitals and other employers of health care workers have written policies regarding HIV infected health care workers, and if so, what they are.

Reference Committee #1 recommended that this resolution be adopted as amended.

HOUSE ACTION: ADOPTED AS AMENDED

Reference Committee #1 recommended that the following reports be **filed for information** as printed in the April issue of the *Journal of the Arkansas Medical Society*.

Report of the Council, J. Larry Lawson, M.D., Chairman
Annual Session Committee, Glen Baker, M.D., Chairman
Insurance Committee, Eugene F. Still, II, M.D., Chairman
Arkansas State Board of Health, M. Joycelyn Elders, M.D., Director
Arkansas State Medical Board, Joe Verser, M.D., Secretary
UAMS, I. Dodd Wilson, M.D., Dean
Crittenden County Medical Society, Steve Schoettle, M.D., President
Garland County Medical Society, Phillip A. Woodward, M.D., Secretary
Jefferson County Medical Society, David C. Jacks, M.D., President
Sebastian County Physicians for Better Health, Eugene F. Still, II, M.D., Chairman
Union County Medical Society, Gary L. Beville, M.D., Secretary

HOUSE ACTION: FILED FOR INFORMATION

Reference Committee #1 reviewed and discussed the following reports which were printed in the April issue of the *Journal of the Arkansas Medical Society* and recommended that they be **filed for information**:

Maternal & Child Health Care Committee, Deborah Bryant, M.D., Chairman
Professional Relations Committee, Charles Rodgers, M.D., Chairman
Young Physicians Committee, David Harshfield, M.D., Chairman

HOUSE ACTION: FILED FOR INFORMATION

Reference Committee #1 gave careful consideration to the following reports and requested that each be considered separately:

Physicians Health Committee
Joe L. Martindale, M.D., Chairman

The Reference Committee felt that this is a very worthwhile activity and that the utilization of these services will continue to increase in the years to come. They recommended that the Physicians Health Committee report be **filed for information** and that the Council explore the possibility

of funding a physician medical director for this committee. The reference committee wished to thank Joe L. Martindale, M.D., for his commitment to and support of the Physicians Health Committee and the impaired physicians of Arkansas.

HOUSE ACTION: **FILED FOR INFORMATION**

Committee on AIDS

William N. Jones, M.D., Chairman

Reference Committee #1 recommended that the Committee on AIDS report be **filed for information** and that William N. Jones, M.D., chairman, be commended for his outstanding efforts on this committee.

HOUSE ACTION: **FILED FOR INFORMATION**

Governmental Affairs Committee - PAC

Charles H. Rodgers, M.D., Chairman

Reference Committee #1 recommended that the Governmental Affairs Committee - PAC report be **filed for information**. The reference committee wished to highlight the importance of this committee's work and urge all physicians to support it.

HOUSE ACTION: **FILED FOR INFORMATION**

Medical Services Review Committee

Charles H. Rodgers, M.D., Chairman

Reference Committee #1 recommended that the Medical Services Review Committee report be **filed for information** and that Dr. Charles Rodgers, the retiring chairman, be commended for his efforts on this committee.

HOUSE ACTION: **FILED FOR INFORMATION**

COMMENTS: Reference Committee #1 further recommends that someone from each reporting institution or committee be present at the reference committee meetings to field questions and comments.

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Reference Committee #2



Joe Wharton, M.D., Warren, Chairman
J. Mayne Parker, M.D., Little Rock
William D. Dedman, M.D., Camden
Anthony N. Hui, M.D., Fayetteville
John Gaston, Little Rock, medical student observer

Resolution from the Pulaski County Medical Society Concerning Opposition to Mandatory Substitution

Whereas, in 1989 the Committee on Drugs and Devices of the American Academy of Family Physicians (AAFP) completed a review of the medical literature regarding generic drugs, and

Whereas, the study by the AAFP revealed reason for concern related to the safety and efficacy of generic drug products, and

Whereas, the AAFP has taken a position stating that there are critical patients, critical diseases, and critical drugs in which there should be *no mandatory substitution* of a generic product for a brand name product, and

Whereas, many members of the Arkansas Medical Society (AMS) provide care to Arkansans who have the cost of their health care provided by agencies (Medicaid) and third-party payors which require mandatory substitution of drug products, and

Whereas, as their patients' advocates, the members of the AMS have the ultimate responsibility for the health care of their patients; therefore let it be

Resolved, that the AMS supports the stand taken by the

AAFP regarding the mandatory substitution of generic drugs for brand name drugs in critical patients, critical diseases, and critical drugs, and be it further

Resolved, that the AMS support legislative activity directed toward the prevention of mandatory substitution of generic drug products for the brand name product and, be it further

Resolved, that the AMS educate its members regarding the generic drug approval process used by the U.S. Food and Drug Administration, and be it further

Resolved, that the AMS encourage the AMA to adopt a similar policy statement.

Reference Committee #2 recommended that the resolution be adopted as written.

HOUSE ACTION: **ADOPTED AS WRITTEN**

Resolution from the Young Physicians Committee Concerning Tort Reform

Whereas, tort reform is one of the major political issues directly affecting the cost of the practice of medicine, and

Whereas, the Georgetown Research Project is an ongoing preliminary study involving five states (the closest being Mississippi) in which an attempt is being made to install a No-fault Workers' Compensation Board rather than the tort system to hear and decide on medical malpractice cases; therefore be it

Resolved, that an appropriate committee of the Arkansas Medical Society monitor and report back the activities of this major American Medical Association effort concerning tort reform.

Reference Committee #2 recommended that the resolution be adopted as written.

HOUSE ACTION: **ADOPTED AS WRITTEN**

Resolution from the Young Physicians Committee Concerning Uninsured Patients (as amended)

Whereas, the problem of 37 million Americans without health insurance, including the uninsured "dependent" population, is being addressed by the American Medical Association, and

Whereas, the Arkansas Medical Society has begun the

Arkansas Health Care Access Foundation to provide free initial visits for qualifying patients in a statewide indigent patient care effort; therefore be it

Resolved, that the Arkansas Medical Society be congratulated for taking a leadership role in this endeavor and to continue every effort to make public, through any reputable media outlet, these commendable efforts along with details on further programs to be undertaken by the physicians of this state to reaffirm our recognition of and continued efforts to resolve these problems.

Reference Committee #2 recommended that the resolution be adopted as amended.

HOUSE ACTION: ADOPTED AS AMENDED

Resolution from the Young Physicians Committee Concerning the Workers' Compensation Ruling

Whereas, the present Workers' Compensation Commission ruling in the Coleman vs. Holiday Inn case could result in a portion of the physician's reimbursement being awarded to attorneys in workers' compensation cases, and

Whereas, the Arkansas Medical Society has filed an appeal along with other affected groups to overturn this unfair ruling; therefore be it

Resolved, that the Young Physicians Committee formally acknowledge its support of the Arkansas Medical Society in their efforts to appeal this precedent setting decision.

Reference Committee #2 recommended that the resolution be adopted as written.

HOUSE ACTION: ADOPTED AS WRITTEN

Resolution from the Arkansas Medical Society Medical Student Section Concerning an Arkansas Medical Society Scholarship Fund

Whereas, the cost of obtaining a medical education continues to rise, and

Whereas, the average medical student graduates with a debt of over forty thousand dollars, and

Whereas, the Arkansas Medical Society Medical Student Section would like to increase the visibility of the Arkansas Medical Society on campus, therefore be it

Resolved, that the Arkansas Medical Society explore the possibility of establishing a scholarship fund to be controlled by either the Arkansas Medical Society or an appropriate foundation.

Reference Committee #2 recommended that the resolution be adopted as written.

HOUSE ACTION: ADOPTED AS WRITTEN

Resolution from the Tri-County Medical Society Concerning Outreach Surgery

Whereas, outreach surgery is a valuable service for patients living at a distance from surgical centers that would make travel to such centers a hardship, and

Whereas, outreach surgery is an important service that may be offered by rural hospitals and is important for their economic survival, and

Whereas, outreach surgery combines surgical care by a physician with an increased level of specialization and pre- and post-operative care by physicians most familiar with the patient's history and medical problems, thereby offers the best of both worlds and is thus a means of delivering the highest quality of care, therefore be it

Resolved, that the Tri-County Medical Society urges the Arkansas Medical Society to support the continued use of outreach surgery and oppose any effort to restrict the delivery of care by outreach surgery by administrative or regulatory action.

COMMENTS: Reference Committee #2 felt that the content of the actual resolution lacked the definition necessary for support by the Arkansas Medical Society. Furthermore, it noted that the Arkansas State Medical Board considered this same issue only days ago and voted that it be tabled. Therefore, the reference committee asked that the Arkansas Medical Society Council monitor developments in this area and make said developments known to Arkansas Medical Society members so that in time, a more definitive position may be reached on this issue.

Reference Committee #2 recommended that the resolution be rejected.

HOUSE ACTION: NOT ADOPTED

Resolution from the Sebastian County Medical Society In Memory of Edward J. Safranek, M.D.

Whereas, God in His infinite mercy has seen fit to call from our midst, Edward J. Safranek, M.D., and

Whereas, Dr. Safranek has faithfully served his patients in the community at-large throughout his entire medical career, and

Whereas, Dr. Safranek, during his years of practice has reflected the highest ideals of his profession, and

Whereas, in his devotion to family, church, and friends, he exemplified the best in man, and

Whereas, the Sebastian County Medical Society mourns his loss, therefore be it

Resolved, by the Sebastian County Medical Society, in its regular meeting on March 13, 1990, hereby adopts this resolution and directs that a copy be spread on the minutes of the Society, a copy furnished to the family, and a copy published in the *Journal of the Arkansas Medical Society*.

Reference Committee #2 recommended that the resolution be adopted as written.

HOUSE ACTION: ADOPTED AS WRITTEN

Reference Committee #2 recommended that the following reports be **filed for information** as printed in the April *Journal of the Arkansas Medical Society*.

Budget Committee, L. J. P. Bell, M.D., Chairman
Committee on Continuing Medical Education, Walter O'Neal, M.D., Chairman
Position Papers Committee, James M. Kolb, M.D., Chairman
Fifth Councilor District, Cal R. Sanders, M.D., Senior Councilor
Eighth Councilor District, Charles Logan, M.D., Senior Councilor
Ninth Councilor District, David L. Rogers, M.D., Junior Councilor
Tenth Councilor District, Morton Wilson, M.D., Senior Councilor
Executive Vice President, Mr. Ken LaMastus, Executive Vice President
Indigent Care Program, Mr. Ken LaMastus, Executive Vice President
Pension Plan Trustees, John Hestir, M.D., Chairman
State Legislative Fund, Charles Rodgers, M.D., Chairman

HOUSE ACTION: FILED FOR INFORMATION

Reference Committee #2 reviewed and discussed the following report which was printed in the April issue of the *Journal of the Arkansas Medical Society* and recommended that it be filed for information:

Medical Education Foundation for Arkansas, Martin Eisele, M.D., Chairman

HOUSE ACTION: FILED FOR INFORMATION

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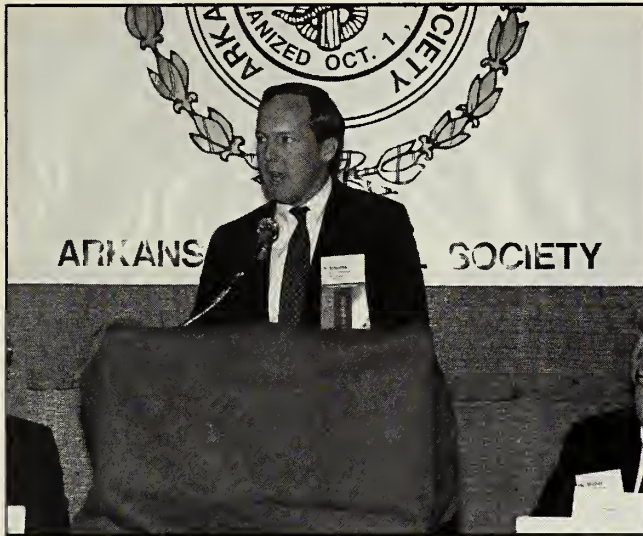
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Reference Committee #3



Steve Schoettle, M.D., West Memphis, Chairman
Simmie Armstrong, M.D.
John L. Lange, M.D.
Amail Chudy, M.D.
David Halinski, M.D.
Scott F. Binet, medical student observer

Reference Committee #3 considered revisions in the AMS Constitution and Bylaws as proposed by the special Task Force on Constitutional Revision and as printed in the April issue of the *Journal of the Arkansas Medical Society*.

Reference Committee Recommendations and House Actions

1. Reference Committee #3 recommended that the revised **Constitution** be adopted as written.

HOUSE ACTION: ADOPTED AS WRITTEN

2. Reference Committee #3 recommended the adoption of Chapters I through IV, VI, VIII, X, and XI of the revised **Bylaws** as written.

HOUSE ACTION: ADOPTED AS WRITTEN

3. Reference Committee #3 recommended the adoption of Chapter V with the following revisions:

- (a) Section 1, last sentence.

The Reference Committee recommended that the language be changed after the word "containing" to read "the names of at least two members for each of the offices to be filled at the Annual Session."

HOUSE ACTION: A substitute amendment was offered by James M. Kolb, M.D. The amendment stated "one or more names for each of the offices to be filled at the Annual Session."

Section 1 was adopted with the substitute amendment.

- (b) Section 6A

The Reference Committee recommended that the number of consecutive terms for the councilors be extended to "four."

HOUSE ACTION: A substitute amendment was offered by Larry Lawson, M.D. to change the number of consecutive terms for the councilors to "six." The substitute motion failed.

Section 6A was adopted as amended by Reference Committee #3.

- (c) Section 6B

The Reference Committee recommended that the following words be deleted: "Provided no member shall serve as Delegate more than eight consecutive years."

HOUSE ACTION: By standing vote, **Section 6B was adopted as amended by Reference Committee #3.**

- (d) After Section 6E

The Reference Committee recommended adding new parts, F & G, to phase in the limits on terms.

F. Provisions of this section shall apply to all current officers and fifty percent of their accumulated years in office shall count toward the specified limits.

G. Once provisions of this section have been implemented, paragraphs (F) and (G) shall be deleted from these bylaws.

HOUSE ACTION: Section 6F and 6G were adopted.

4. Reference Committee #3 recommended the adoption of Chapter VII with the following revision:

Section 2: Add the following: "There shall be two councilors from each district which has two hundred members or less. In districts where there are more than two hundred members, there shall be an additional councilor for each additional one hundred members. The councilors shall serve staggered terms of two years each. All councilors shall have equal voting privileges. A majority of the voting members shall constitute a quorum."

This part was supposed to be transferred from Article VIII, Section 2 (page 455 of the April *Journal*), but was not.

HOUSE ACTION: ADOPTED AS AMENDED

5. Reference Committee #3 recommended the adoption of Chapter IX, with the following revision:

Chapter IX. Add to the end of the sentence: "provided, written notification has been given prior to a person missing the critical number of absences."

HOUSE ACTION: ADOPTED AS AMENDED

Speaker Crenshaw thanked the members of Reference Committee #3 as well as Warren Douglas, M.D., chairman of the Constitution and Bylaws Revisions Committee, for their hard work.

Speaker Crenshaw asked the chairman of the Council, Larry Lawson, M.D., to give his Report of the Council which meets daily during the meeting.

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Report of the Council

J. Larry Lawson, M.D., Chairman



The Council met on Thursday, May 3, 1990 at the Arlington Hotel in Hot Springs. The following business was received and transacted:

1. Approved the minutes of the March 4, 1990 Council meeting.
2. Approved the minutes of the March 28, 1990 Executive Committee meeting.
3. Approved the Budget Report for the quarter ending March 30, 1990.
4. Approved the 1989 AMS Audit prepared by Ferguson, Cobb, and Associates.
5. Approved the membership report for the period ending March 30, 1989.
6. Approved the request for dues exemptions as presented in the attached agenda.
7. Heard a report on the attorney general's ruling pertaining to the Rights of the Terminally Ill Act. Mr. Mitchell also reported that at this time there are no changes in the Workers' Compensation lawsuit.
8. Michael Moody, M.D., discussed Certified Rural Health Clinics.
9. William Jones, M.D., discussed his recent testimony to the Subcommittee on Health and Environment in Washington, D.C.
10. AMA Board of Trustee Robert McAfee, M.D., of Portland, Maine, greeted the Council.

The Council met on Friday, May 4, 1990. The following business was received and transacted:

1. Martin Eisele, M.D., discussed the purpose and goals of the Medical Education Foundation for Arkansas.
2. Approved the restructure of the Arkansas Medical Society committees as presented in the attached agenda.
3. Approved a motion to form an ad hoc committee to study a proposal for perinatal care access.
4. Robert Barnes, M.D., professor and chairman of the Department of Surgery of the UAMS, discussed a study group on Small Area Analysis of Variations in the performance of Carotid Endarterectomy in Arkansas.
5. Approved the MED-PAC officers as follows:
District 1: Joe Stallings, Jr., M.D., Jonesboro
District 2: Michael Moody, M.D., Salem
District 3: Les Anderson, M.D., Lonoke
District 4: Lloyd Langston, M.D., Pine Bluff, Vice Chairman
District 5: Don Howard, M.D., Fordyce
District 6: Robert Sykes, M.D., Nashville
District 7: Doane Newton, M.D., Hot Springs
District 8: Charles Rodgers, M.D., Little Rock, Chairman
District 9: Robert Langston, M.D., Harrison
District 10: Paul Wills, M.D., Fort Smith

The Council met on Saturday, May 5th, and the following business was received and transacted.

1. Passed a motion concerning Certified Rural Health Clinics and instructed the AMS staff to:
 - a. Discuss the advantages and disadvantages of reviewing Medically Underserved Area (MUA) and Health Manpower Service Area (HMSA) designations with the Office of Primary Care.
 - b. Ask the governor's office to request an updated review of these designations.
 - c. Ask the Arkansas State Medical Board to clarify the physician's responsibility in supervising physician assistants.
 - d. Ask the Arkansas Department of Health to delay certification of the Rural Health Clinics until updated information is available.
2. Passed a motion that a representative of the Arkansas Medical Group Management Association be invited to attend Council meetings.
3. Morton Wilson reported on the staff, committee, and membership changes in the PRO.

4. The following Council committee appointments were approved:
 - a. Medical Services Review Committee:
 - Family practice: Dennis Davidson, M.D., Batesville
 - Internal medicine: Homer K. Beavers, M.D., Russellville
 - Ob/Gyn: H. Aubry Talley, M.D., El Dorado
 - Orthopaedic surgery: Marion P. Hazzard, M.D., Paragould
 - Pediatrics: Doane Newton, M.D., Hot Springs
 - Pathology: John E. Slaven, M.D., Little Rock
 - b. Medical Services Review Committee Sub-specialties:
 - Thoracic surgery: Leon P. Woods, M.D., Fort Smith
 - Gastroenterology: Thomas J. Smith, M.D., Little Rock
 - Plastic surgery: R. Cole Goodman, M.D., Fort Smith
 - Pulmonary disorders: John C. Schultz, M.D., Little Rock
 - Pediatric allergy: Joseph W. Matthews, M.D., Little Rock
 - Cardiovascular surgery: G. Doyne Williams, M.D., Little Rock
 - Nephrology: James A. Wellons, M.D., Little Rock
 - Oral surgery: Robert Anderson, D.D.S., Little Rock
 - Emergency medicine: Eugene M. Shelby, M.D., Hot Springs
 - c. Medical Education Foundation for Arkansas, Amail Chudy, M.D., Little Rock
 - d. Committee on Position Papers:
 - James M. Kolb, M.D., Russellville
 - George W. Warren, M.D., Smackover
 - W. Payton Kolb, M.D., Little Rock
 - Roger Cagle, M.D., Paragould
5. The following officers' reports were made:
 - a. Glen Baker announced the convention registration figures.
 - b. A motion was passed to write a letter to Deborah Bryant, M.D., commending her for her work and efforts while working with the Arkansas Department of Health.
 - c. Approved a motion for the Budget Committee to consider purchasing two fax machines placing one in the office of the president and one in the chairman of the council during their terms of office.
 - d. Heard a report by Ray Jouett, M.D., on the plan to complete the move of the Arkansas State Medical Board to Little Rock by July 1991.
 - e. Passed a motion for the Council to commend the Arkansas State Medical Board Report given by Dr. Jouett and go on record supporting the move from Harrisburg to Little Rock.
 - f. Passed a motion by the Budget Committee to main-

tain the present reimbursement procedure for the office of the president. Reimbursement to equal actual incurred expenses.

There being no further business the Council adjourned.

Speaker Crenshaw announced the following nominations:

Arkansas State Board of Health:
 Second Congressional District, Kenneth Meacham, M.D., Searcy
 Fourth Congressional District, Sanford Hutson, M.D., Lewisville
 Arkansas State Medical Board:
 Member-at-Large Position, W. Ray Jouett, M.D., Little Rock, renominated.

Speaker Crenshaw also announced the officers for the 1990-1991 Nominating Committee as follows:

Charles Logan, M.D., Little Rock, Chairman
 David Rogers, M.D., Fayetteville, Secretary.

There being no further business the House was adjourned.

INTERNAL MEDICINE - Board certified or board eligible internist needed to join largest multi-specialty group practice in state. This 75-physician clinic is located 75 miles north of the Mississippi Gulf Coast. Excellent opportunity with competitive salary and fringe benefits leading to partnership. College town of 50,000 with a drawing area of 300,000. Contact: Russell A. DeGeorge, Assistant Administrator, Human Resources Hattiesburg Clinic, P.A., 415 South 28th Avenue, Hattiesburg, MS 39401. Call (601) 268-5609.

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William N. Jones, Little Rock, President
George Warren, Smackover, President-Elect
Michael N. Moody, Salem, First Vice President
Linda A. Markland, Fayetteville, Second Vice President
J. Warren Murry, Heber Springs, Third Vice President
Charles Rodgers, Little Rock, Secretary
James M. Kolb Jr., Russellville, Treasurer
John Crenshaw, Pine Bluff, Speaker, House of Delegates
Kelsy J. Caplinger III, Little Rock, Vice Speaker, House of Delegates

EXECUTIVE COMMITTEE

J. Larry Lawson, Pargould, Chairman of the Council
William N. Jones, Little Rock, President
George Warren, Smackover, President-Elect
Charles Rodgers, Little Rock, Secretary
James R. Weber, Jacksonville, Immediate Past President

COUNCILORS AND COUNCILOR DISTRICTS

FIRST DISTRICT

J. Larry Lawson, Pargould (1992); Merrill J. Osborne, Blytheville (1991). Clay, Craighead, Crittenden, Greene, Lawrence, Mississippi, Poinsett, and Randolph Counties

SECOND DISTRICT

John E. Bell, Searcy (1992); Jim E. Lytle, Batesville (1991). Cleburne, Conway, Faulkner, Fulton, Independence, Izard, Jackson, Sharp, Stone, and White Counties

THIRD DISTRICT

L. J. P. Bell, Helena (1992); Hoy B. Speer, Jr., Stuttgart (1991). Arkansas, Cross, Lee, Lonoke, Monroe, Phillips, Prairie, St. Francis, and Woodruff Counties

FOURTH DISTRICT

Paul A. Wallick, Monticello (1992); Lloyd G. Langston, Pine Bluff (1991). Ashley, Chicot, Desha, Drew, Jefferson, and Lincoln Counties

FIFTH DISTRICT

Cal R. Sanders, Camden (1992); Wayne G. Elliott, El Dorado (1991). Bradley, Calhoun, Cleveland, Columbia, Dallas, Ouachita, and Union Counties

SIXTH DISTRICT

James D. Armstrong, Ashdown (1992); F. E. Joyce, Texarkana (1991). Hempstead, Howard, Lafayette, Little River, Miller, Nevada, Pike, Polk, and Sevier Counties

SEVENTH DISTRICT

Ronald J. Bracken, Hot Springs (1992); Thomas H. Hollis, Hot Springs (1991). Clark, Garland, Grant, Hot Spring, Montgomery, and Saline Counties

EIGHTH DISTRICT

David L. Barclay, Little Rock (1992); Harold Purdy, Little Rock (1992); R. Jerry Mann, Little Rock (1992); Paul Cornell, Little Rock (1991); Charles Logan, Little Rock (1991); Warren Douglas, Little Rock (1991); Glen F. Baker, Little Rock (1991). Pulaski County

NINTH DISTRICT

Robert H. Langston, Harrison (1992); David L. Rogers, Fayetteville (1991). Baxter, Benton, Boone, Carroll, Madison, Marion, Newton, Searcy, Van Buren, and Washington Counties

TENTH DISTRICT

Morton C. Wilson, Fort Smith (1992); A. C. Bradford, Fort Smith (1991); Gerald A. Stolz, Russellville (1992) Crawford, Franklin, Johnson, Logan, Perry, Pope, Scott, Sebastian, and Yell Counties.



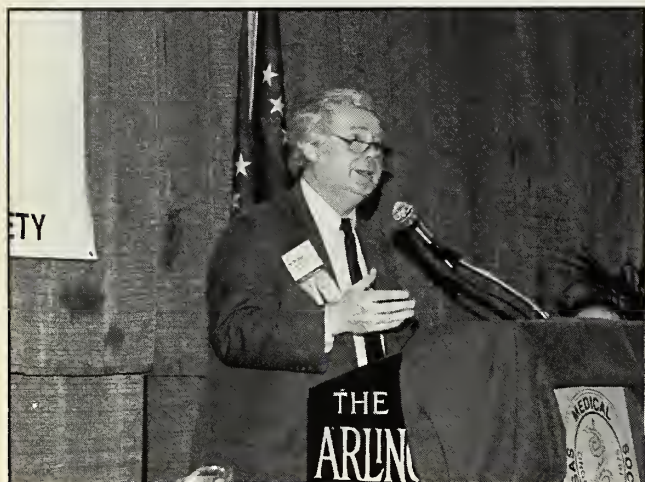
1990 AMS



Annual Session



Address by James R. Weber, M.D. 1989-90 President



Mr. Speaker, fellow physicians, members of the Auxiliary, and guests, it has been a great honor and a very rewarding personal experience to have served as president of this Society. I deeply thank you for that opportunity.

We Are The Patient's Advocate

This past year my most impressive experience has been to observe firsthand the untiring dedication of our doctors in their efforts to continue to provide to their patients the highest quality health care available in the world, both personal and technical, in an environment that is not as friendly as it should be.

There is intense third party interference today on all levels, an ocean of unproductive paperwork, more and more hassle from medical reviewers, and more difficulty getting paid a fair fee at a time of greatly increased practice costs.

It is clear to me that the Physicians Regulatory Relief Amendments of 1990 (The Anti-hassle Bill) introduced in Congress April 14 is long overdue.

It is our job and challenge today in organized medicine to be proactive in this almost purely cost driven system and to be sure that the invaluable experience and knowledge from the doctor out there doing the job day after day is organized, and is heard in the planning of our health care policies for our patients. This is what the State Medical Society and the AMA do best.

Foundation For Health Care Access

It has been said that where there is dehumanization of medical care there is loss of philanthropy. I can assure you that

neither has occurring in Arkansas this past year. I had the great privilege to publicly announce, on your behalf, the establishment of the Arkansas Physicians Care Program on September 18, 1989. A program to help financially destitute families gain access to the health care system and to a caring physician. A program developed under the leadership of the three past presidents of your Society.

I am delighted to report that after six months of operation, over 6,000 patients have been approved for eligibility. Interestingly, the greatest concentration has been in the northeastern part of the state where unemployment is highest (13%) and surprisingly the lowest concentration is in the southeastern delta where we all perceived would be the most desperate need.

I want to publicly thank you, the physicians, who participated as well as the dentists, the many hospitals, the pharmacies, the home health agencies, the public health facilities, the Department of Human Services, and the members of the Arkansas Senate and House, who have all volunteered and contributed to this unique and successful effort. This program was created by you and your medical society.

33 Million Uninsured Americans

In looking to the future, it is true that approximately 33 million Americans and approximately 600,000 Arkansans have no health insurance (about 1/4 of our state's population). This is one of our greatest challenges today and one that must be solved.

Seventy-five percent of these citizens have jobs but make less than \$10,000 per year. If their pay was higher, that would help. One must obtain an education to get a good paying job today, and jobs must be available. Their employer either does not provide health insurance or the worker has insurance but the dependents are not covered. If a method could be found to enable small businesses to afford basic health insurance without financial ruin, that would help. A tax credit when there is no profit is not enough help. About 1/3 of these 33 million are women below the poverty level, about 1/4 are true poor. Less than 1% are the medically uninsurable.

At the Chicago AMA meeting last year, the AAFP presented a plan to cover these citizens with health insurance building on the strengths of the private sector. A number of Arkansas family physicians right here in this room today played an important role in the development of this plan that was adopted by the AMA House of Delegates and is now a part of the AMA Access to Care Program to provide health insurance for all Americans. We must make this happen.

Medicare

On July 30, 1965, when Title XVII (Health Insurance for the Aged, Medicare) was established, the driving force was access to care. I entered private practice in 1962. This year (1990) in Arkansas access to health care for the Medicare

patient is again a major concern. The basic reason is that Medicare reimbursement is far below today's cost of providing many services especially the office calls and consultations that the access point to the health care system. The staff and officers of your Society have been meeting with leaders of the AARP on a monthly basis to work together to help improve the problem of access to care for our senior citizens. I am convinced that this will not be changed without the support of our Medicare patients in a joint effort.

Not only must the House of Medicine stand together today, but also we must make a greater effort to join with our patients, or listen to their concerns, and to work for improvement together. When you take most of the doctors and most of their patients working together, you have a powerful coalition.

Medicaid

As you know, the Medicaid program is funded by a 3 to 1 match by federal and state funds. Our legislators are always excited about getting more federal money.

What is federal money? Federal money is the money you and I and our patients used to have.

I have looked at federal money much like a self-blood transfusion. Blood is taken out of the right arm and transfused into the left arm, with half of it being spilled in the process. It is no wonder that the federal Treasury gets more anemic, and with this system, both the donor and the recipient become anemic quickly.

It is true, though, that the 3 to 1 matching federal funds do help the economy of our state but most importantly, the funds provide health care for some of our citizens who are in greater need.

Today I hear our physicians saying, "I can't get paid for the Medicaid work I do and the hassle factor has become too great."

It is true that the EDS computer runs a claim through 300 audits before the claim is paid. It is astounding that approximately 40% of all claims submitted are rejected one or more times. Personally I have seen cases where the cost of the paperwork following a Medicaid claim rejection has exceeded the total reimbursement expected for the medical service. The final computer generated a letter that stated, "the time for payment has expired."

Many of the doctors with whom I have talked who have stopped taking Medicaid patients say that the payment would be okay since they consider this to be partly a charitable responsibility, but the hassle factor dealing with the computer and the bureaucracy was just too great.

At this time only about 10% of Arkansas physicians are sending in Medicaid claims on a regular basis. The good news is that our present Medicaid officials do recognize that without doctors there is no program, and they are anxious to make improvements and reverse this trend. I want to report to you that we have been meeting with Medicaid officials regarding these problems and there is a renewed spirit of co-

operation and joint effort to help decrease these hassle factors and to raise some reimbursements such as OB services and office visits.

RBRVS

Physician reimbursement under Part B of Medicare has been a major issue this past year with the adoption of the Harvard Resource Based Relative Value System first at the AMA House of Delegates and eventually by Congress. Now it is to be implemented over a five year period beginning in 1992 and is to remain budget neutral.

Since 1985, I have had the privilege to serve on the Harvard study as one of the 100 physicians from across the country. In fact, I will be going back to Boston again in a couple of weeks.

As Phase I of this study was completed, I was personally convinced that it was valid and that payment according to the



resources involved in providing a service or procedure was a fair way to reimburse physicians for their work. I have always been concerned however, that the agents of government might use the RBRVS with no present actions being taken could possibly invalidate the entire RBRVS even before it is implemented.

As you know, nearly 200 procedures have already been designated as "overpriced" and targeted with a 15% reduction in payment by Medicare before the implementation of RBRVS.

If it is to remain budget neutral, as the law requires, this type of action shrinks the total pie to a point where, when implemented, there would be little real payment gain in actual dollars for the already grossly underpaid evaluation and management services. Further, as the RBRVS is phased in, it would excessively lower the payment for surgery and

procedures. Just as critical are the payment for surgery and procedures. Just as critical are the proposed cuts based on the Medicare Volume Performance Standards before phasing in the RBRVS. We have a serious budget deficit but we must not have a cerebral deficit in the solutions. We must prevent this unfair tampering with the RBRVS.

Recently, we were appalled to learn that the geographic differential RBRVS conversion factor for Arkansas was the lowest in the nation. In addition, the limit placed on maximum allowable charges to 125% of the Medicare prevailing immediately placed many MAAC's in Arkansas actually below the cost of providing the care. This in mandatory assignment through the back door. Our senior citizens pay exactly the same Medicare Part B premium as is paid in all other states. Why should their benefits be so much lower?

Medical Malpractice

Your Society has taken an active role in all areas regarding malpractice issues. In the last session we did defeat a plaintiff attorney bill that would have increased your premiums by 25% overnight, according to the carriers.

Arkansas doctors should be commended for their risk management efforts and for attending those activities sponsored by this Society. The number of claims received by St. Paul, the largest carrier, has decreased from a high of 196 in 1985; to 52 the first 9 months of 1989. Incidentally, there were no million dollar judgments in 1989. Our recruitment of new insurance companies has created a competitive market. This, with risk management and the reduction in the number of claims, has played a major role in the 12% average premium reduction that St. Paul announced last week.

PRO

The PRO underwent progressive change this past year. I would say that the orientation has become one of being more helpful, more willing to listen to the memberships concerns, and more oriented toward education and rehabilitation rather than being purely punitive. These changes were brought about by the action of the members.

It is of extreme importance that everyone stay Sunday and attend the annual meeting of the Foundation. Your input is needed and your participation is of the greatest importance.

Society Staff

I must personally thank Ken LaMastus, Lynn Zeno, Peggy Cryer, David Wroten, and all of their staff. Their performance has been outstanding during this past year in the true sense of excellence. I will always greatly value our personal friendship and again I thank them for their great support.

This has been a year that has seen a major restructuring of our committees and our bylaws to streamline the manage-

ment of our activities and increase our ability to respond quickly and effectively to major issues, a handicap we had to overcome.

We have successfully put a new emphasis on students and young physicians, recognizing that they are the leaders of tomorrow. Young physicians have been appointed to almost every committee, and the Young Physicians Committee is one of our most active.

I would especially compliment the work of the AIDS Committee for educating almost 6,000 high school students about the AIDS epidemic this past year.

The Society recognizes the strong support of the Auxiliary and I commend them for their impressive success with the development of the DWI program. I also commend them for their legislative influence.

this year I have learned a great deal and have made some astounding observations.

The Golden Fleece Award would, of course, go to the Medicaid computer that rejects 40% of the claims.

Medicine Man of the Year award goes to Congressman Pete Stark for his subconscious love of the medical profession.

Would you believe the out of pocket financial contribution made by many of our physicians in providing care to Medicare and Medicaid patients in this state is greater than the total of their state and federal income tax combined?

Underpayment by Medicare and medicaid is a major cause of the increase in the cost of health insurance in the private sector. Today there is no place left to shift costs and if the system is to remain viable the government programs must pay their fair share.

Election Year

I would remind you that this is an election year.

Just to mention a few:

A fellow physician, Dr. Hampton Roy of Little Rock, is a leading candidate for Lt. Governor.

Your Auxiliary president, Nikki Lawson of Paragould, is a candidate for the House of Representatives.

Wanda Northcutt, wife of Dr. Carl Northcutt of Stuttgart, is running for her second term in the House of Representatives.

Many more of our friends are candidates for public office.

The Governor has recently come out publicly for National Health Insurance (Medicare and Medicaid for all).

It is said that our American Society consists of three groups of people. Those who make things happen, those who watch things happen, and those who wonder what's happening.

Get behind those candidates that will make things happen to promote an environment that is friendly and helpful to the doctors caring for the people of this great state and nation.

You and I are people who make things happen. Thank you and God bless everyone of you.



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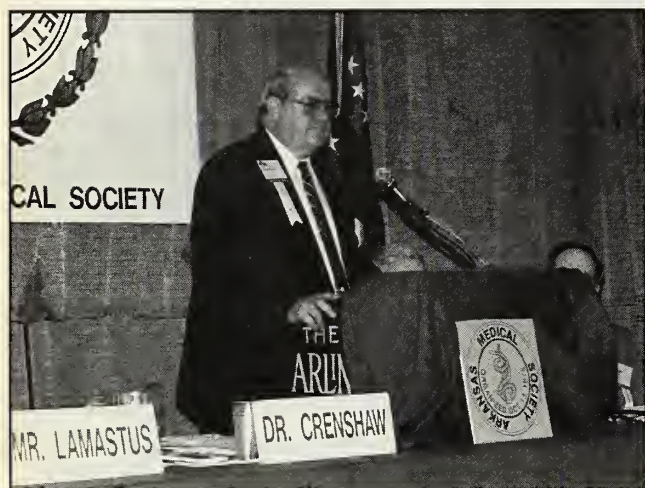
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Address by Robert E. McAfee, M.D.

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Caring: The One Quality That Won't Change In The 90's

It is a real pleasure to be here. In considering your invitation to speak about the future of health care in the 1990's, it seemed appropriate to focus on the importance of caring and our relationships with patients. Maybe it comes as a surprise, that in a technological age that grows more complex by the nanosecond, that I would focus on something as traditional, simple, and unchanging as caring.

But, perhaps it is precisely because it is so simple that we tend to overlook its central, critical role in the future of medical care.

We often hear comparisons of health care to a three-legged stool with access, cost, and quality as the legs. But we tend to miss the obvious, and the obvious is that the actual platform, supported by access, cost, and quality is caring. That's what the three legs ought to support.

And maybe it seems a little surprising until you think back to why you wanted to be a physician in the first place. For don't you see yourself, first and foremost, as healers of disease and of injury, as compassionate caregivers to people who need our help? The services we offer to our patients are truly very intimate services. And one of the greatest satisfac-

tions of medicine is the unique bond that we have with our patients. No matter what our specialty may be, the uniquely close encounters we have with our patients are close encounters of the best kind!

Let me describe what I mean by retelling a story. One of my colleagues in Maine, a highly respected orthopaedic surgeon, told me about a patient of his, an elderly, retired lobsterman, who came to the hospital for an operation on his knee. The patient for a time did well and then developed urinary complications and needed a prostatectomy. During the procedure, the knee dislocated. Then a cascade of events, leading to about six different operations over almost a two year span, culminated in amputation above the knee. When the patient came in to have his stitches removed, he looked up at the physician and said, "Doc, you've done a good job."

My friend just didn't know what to say at this point. He shook the lobsterman's hand, turned, and went into the office and shut the door. The physician said to himself, "I have failed the patient. My patient wanted a simple operation and he ended up losing his leg." But then he began to think about the patient and he realized that even though the patient understood the reasons why the operation wasn't successful, he didn't see the outcome in the same way that the physician, the nurses, and the hospital looked upon it. What the lobsterman had seen was not the quality of care, but the quality of caring that every single person and institution exhibited toward him every single time he came into the hospital, whether it was the admitting clerk, the housekeeping people, the security people, the nurses, or the physicians! What he could see is that they were all concerned for him and, in fact, loved him and wanted him to be well, even though it just wasn't in the cards. And so when the stitches were removed he said, "Doctor, you've done a good job." Perhaps there is a lesson for us in that.

I think that what is happening to our health care system today is that we are concentrating too much on the quality of care as perceived by professionals and as perceived by systems. We are rightly concerned about access and the specter of possible rationing. We are rightly concerned about the cost of care and its ramifications for access. And, we are justifiably proud of the advances we have seen in technology which makes the quality of care better on a day-to-day basis for patients.

But our patients don't see these things as we do. And they don't understand why all the other concerns, like third-party payers, extensive paperwork, and the demands of high technology, seem to take time away from a health-care system that should spend more money caring for them.

The nursing crunch is just one example. The reason that the intensity of care in the hospital has reflected on that crunch is because the nurses, very frequently, have had to choose between being with the patient at bedside and being with the computers at the nurses' station and the other high-tech accouterments of health care in the 90's. I don't think the nurses like it anymore than the rest of us.

And maybe we ought to consider where the patient comes in. We often think that our patients ought to be forever grateful for what we have given them, yet when asked the overwhelming majority of Americans say they would prefer to have some other health-care system. And I don't really think it's because of the cost. I think it's because they can't see and measure the quality of care provided by the new technology, but they do tend to perceive a lack of caring as compared to what patients used to see in the past.

You may have seen the article in the New York Times just a few days ago. It said that "Wariness is Replacing the Trust Between Physicians and Patients." That was the headline. It went on to refer to an adversarial relationship that has evolved between health-care providers and patients. It is true that the whole professional liability mess has played an important role in this.

And the problem grows out of modern medicine today. The problem is simply that while there is so much more we can do for our patients, there is also so much more that can go wrong!

And wrong almost always implies error and negligence. Today, there is virtually no organ, tissue, or cell in the human body that is beyond medical reach. For example, major surgery necessarily involves major injury to the patient. And it opens up the possibility of all kinds of liability problems doctors didn't have when all they could do was sit by a patient's bedside round the clock and give him comfort.

Add to this the phenomenon that technology itself is often cold and impersonal to our patients. In fact, recent studies indicate that patients sue less often because of bad outcomes than because of what they perceive as unfeeling treatment.

Caring is really the key. In this computer age, it is an old-fashioned, even ancient virtue as true in the days of Alexander the Great, as it is today. On his march through Asia Minor, Alexander fell dangerously ill. His physicians were afraid to treat him because if they did not succeed the Macedonian army would suspect them of malpractice. Only one, Philip the Acarnanian, was willing to take the risk because he had confidence in both the king's friendship and his own drugs. While the medicine was being prepared, Alexander received a letter from an enemy of Philip's that accused the physician of having been bribed by the Persian king to poison his master. Alexander read the letter and slipped it under his pillow without showing it to anyone. When Philip entered the tent with the medicine, Alexander took the cup from him, at the same time handing Philip the letter. While the physician was reading it, Alexander calmly drank the contents of the cup. Philip was horrified at this falsehood and he threw himself down at the king's bedside. But Alexander assured him that he had complete confidence in Philip's honor. After three days the king was well enough to appear again before his army.

I guess this story shows us that caring is a timeless quality and an essential element of the doctor-patient relationship. I would add that the fact is that our professional

liability problems are more a symptom of problems in the doctor-patient relationship than the cause.

And the cause, very often, is that we are so busy providing the highest possible quality of care, in terms of state-of-the art technology, so busy battling the third-party payors so that patients can receive the services they need, so overwhelmed by the increasing demands of paper work, that we simply run out of time to show how much we care.

Physicians take considerable pride in state-of-the art technology resources and techniques we employ on our patients' behalf. But patients who are about to be anesthetized and surgically incised may very well have an entirely different point of view! They may be frightened, both by their condition and by the technology. If we can look at high tech through the patients' eyes, we can prepare them for what they are about to undergo.

Instead of being somebody who's going to do something to them we can be a personal guide, the one person who can provide the human connection to take them through this experience with confidence. I think it is time to revise our notions of quality and make them a little more in sync with the perceptions of the patient. As the highly respected ethicist, Daniel Callahan, says in his new book *What Kind of Life: The Limits of Medical Progress*, "Caring is the foundation stone of respect for human dignity and worth upon which everything else should be built. Its presence can be a steady and faithful one even in the inevitable absence of resources to carry forward the open-ended enterprise of cure."

An interesting observation, and one that poses a challenge. We can talk all day about lofty concepts, but ultimately caring for patients is a one-on-one day-to-day proposition.

Every day you make decisions that draw on the ethical base of medicine. Every day you have a chance to renew the prestige that patients have conferred upon our profession. And every time it is renewed we chip away at the credibility of outside forces who would like to establish a new hierarchy in health-care delivery with someone other than a doctor at the top. It is your challenge, as it is mine, to see that this tradition of caring is not lost, but preserved, built upon and enhanced in the decade to come.

Sure we should all concern ourselves with the many trials and tribulations that will beset us in the 1990's. Certainly, let's worry about efforts to reduce physician compensation, to hamper scientific advances, and to limit physician autonomy. Let's tackle problems like inadequate access to health care services for the millions of Americans who are uninsured, under-insured, or uninsurable.

And let's help to promote the AMA's Health Access America program and do whatever else needs to be done to extend the blessings of adequate health care to every citizen.

Caring is the one quality that will not change in the 1990's and we must never lose sight of that responsibility. If we can do that, then the future of our profession is well assured. Thank you very much.

Address by M. Joycelyn Elders, M.D.
Director, Arkansas Department of Health



It is likely that I have talked with almost everyone here at one time or another. Even if I didn't teach you, I probably talked with you, and I feel that I know many of you. I want to thank you for the support you have given me during the past two and a half years. Many of you work with the public health nurses in your community. I want you to know that I don't feel they are my public health nurses. They are your public health nurses. I am your director. We consider our job to be to help you help the citizens of Arkansas.

I want to talk with you today about what we must do to prepare for the 21st century. I want you to think about something I read the other day. It compared the health of six industrialized nations--the U.S., Canada, England, Sweden, France, and the Netherlands. Using the common measuring sticks of infant mortality, care for the elderly, teen pregnancy and premature deaths, our country did not do very well. This is despite the fact that last year the U.S. spent \$660,000,000,000 on health care or 12% of our gross national product. Ninety percent of that was spent on the last month of life, and less than 1% was spent on prevention. Yet, we all know that the best way to have good health is to prevent disease.

Measles is a good example. We could eradicate measles from the earth, but the number of cases is on the rise in this country. We say we don't have the money for vaccine. However, the cost to immunize all the children in this nation who need it would be less than the amount necessary to purchase one bomber. We are not paying attention to prevention.

I know that you are busy in your everyday practice. I was busy with teaching and doing research before I took this job. One of the things I have learned since becoming your health director, though, is that the people who write and make the policies are not doctors. Most of us are not involved. We are going to have to become more involved in deciding national

policies, instead of reacting to them once they are out--which is what we have been doing.

As we plan for the Year 2000 national health goals, you are going to see a lot of me. I will be calling on you to help and decide the goals for Arkansas and plan how to meet those goals.

In Arkansas, we need to continue to address improving our infant mortality rate. Also, since 1950, there has been little improvement in the percent of births which are low birth weight. We are going to have to do some things differently. Japan has reduced their infant mortality rate from 22 per 1000 to 4.5 per 1000, while we have reduced ours from 18 per 1000, to 10 per 1000; their low birth weight percentage has dropped to 3.4%, while ours has remained near 7% for 40 years. In addition, 11% of our births are now involved with drugs, and AIDS is becoming a greater concern for newborns. I am happy to report, however, that in a recent study only 0.5% of the infants in Arkansas tested positive for AIDS, compared to the national average of 2.5%.

Arkansas has 27 counties that do not have a single doctor who provides maternity care. This is a problem we must solve. The Health Department is willing to work with you in a variety of ways to address this problem--to do the prenatal care and you do the delivery, to have you see your Medicaid patients in our clinic, or whatever it takes. I also want you to know that we are embarrassed that we take care of patients until the time of delivery and then send them to you. The only thing that would embarrass me more would be if the women received no prenatal care.

Of the 23 national health objectives for the Year 2000, 17 can be impacted by health education. Yet, we do not teach health education. We do not teach it in the schools. These national objectives can also be impacted by preventive measures. And yet, we have not practiced it. Our insurance

companies do not pay for it. And all the while, 64% of all premature deaths are preventable.

An enduring public health problem is adolescent health. We have not done well by our children. Thirty-four percent of our high school seniors have a problem with drugs, 50% of our 12-17 year olds (babies as far as I am concerned) consume more than a carton of beer a week, and 30+% have a major problem with alcohol. Our homicide and suicide rate is the highest of all industrialized countries, 431 times higher. This is the only age group where the morbidity and mortality increased during the past ten years. It has risen 12% due to drugs, alcohol, homicide, suicide, and teen pregnancy--all of which are preventable.

I was sick to see the problem this week in Sheridan. The front page of the Arkansas Gazette carried this story, and immediately below it was a story of five teenagers who had committed a murder and robbed a liquor store. They were all less than 19 years of age.

Another statistic which really bothers me concerns 19 to 29 year olds in prison. Who knows the percent of these youngsters, warehoused in our prisons today, who were born to teenage mothers? It is something we don't think about. The answer is 90%! For the \$27,000 a year it costs Arkansas to care for each prisoner, we could send him to Harvard or Vanderbilt.

Adolescent pregnancy is not a simple problem. Arkansas spends \$100,000,000 a year taking care of teenagers and their families. Seventy-two percent of them remain on AFDC for years to come.

There are several ways we must begin to address this problem.

First, we must have early childhood education. We need to make sure that low income children enter the first grade ready to learn, like their more affluent counterparts.

Second, we must have comprehensive health education programs in our schools, beginning in kindergarten. Junior high and high school is too late for our at-risk children. Everybody worries that somebody might teach them something about sex, but I want you to know that if you have the highest birthrate to teens in the world, they must know something already. At the same time, AIDS is the disease increasing most rapidly in our teenage population. Somebody needs to teach them how to be responsible. We have not taught our bright young people responsibility, and they have a lot of very costly, incorrect ideas.

Third, we must educate our parents and strengthen our families. Many parents don't know how to be good parents. We think all families are just like ours, but we're talking about thirteen year old mothers and nineteen year old mothers with five babies. Only 37% of the young black men in this country earn enough to support a family. Thirty-four percent of them never finished high school.

And, of course, you all know that I have been a real proponent of comprehensive school-based health services. Our children from age 5 to 25 get very little health care. Unless they are on a sports team, after age five they are not

likely to see a doctor again for preventive health care.

We are not taking good care of our children. We can do better. We have the resources. We must make the commitment. I have asked our good suit club to make sure that all of our children with a B average or higher, who want to go to college, have a package available to them to provide for tuition and books. Let's give them hope.

In summary, as we prepare for the 21st century, we as doctors must get more involved. Many of you are involved. I have felt your involvement as I have been in your community. But, we must get more involved and make a difference. We must seize every opportunity. We have got to start being the powerbrokers for the powerless. We have got to be real advocates for the changes we feel are necessary. We have got to be the leaders. We must develop an action plan for Arkansas to make sure our people have access to health care.

Together, let's develop the plan that we want. Let's develop a plan to make sure preventive health care is provided. Let's develop a plan to make sure comprehensive health education, which can do more for us than all of science, is there for our bright young people when and where they need it. Let's develop a plan to make Arkansas the pacesetter.

We can. We know how, and I think we are willing to accept the challenge and be the pacesetter for the nation. Thank you.

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Address by Mrs. J. Larry Lawson

1989- 90 President

Arkansas Medical Society Auxiliary



Mr. Speaker, Dr. Weber, members of the House of Delegates, and honored guests:

Thank you for this opportunity to talk with you. It gives me a chance to emphasize something that I think is one of the most vital elements in the auxiliary's efforts to make a difference in the health and quality of life for others - the element of teamwork between the medical society and the auxiliary.

Our local auxiliaries have been active in setting up a grass roots legislative network to help the society present a unified voice for sound medical legislation. Pulaski County auxiliaries have already had an orientation workshop with Lynn Zeno and a tour of the Capitol. They will have auxiliaries at the capitol for every session of the 1991 Legislature.

To promote the image of medicine in the community, auxiliaries have been a visible force in promoting such adolescent health projects as teen pregnancy awareness, no smoking campaigns, teen resource guides, and crisis cards.

In the areas of medical education, I presented \$1,000 checks to two medical students at the annual Parent's Awards Luncheon on behalf of the Society and the Auxiliary from AMA-ERF donations.

We are continuing our efforts to help the medical family in times of crisis with our Arkansas Medical Society Auxiliary Support Hotline.

Our most important effort, the DWI video campaign, has created co-operation with many health organizations and volunteer programs. We have, with the help of the society

office, established a project which will give medicine a positive public image and, most importantly, it will help teens inform their peers to not drink and drive. A special thanks to Sandra Young, M.D., who asked the auxiliary to undertake this project. This project has been implemented and chairmen are busy making contacts. Our entire \$9,100 budget has been met. Please drop by our booth in the exhibit area and look at our projects.

I would like to thank the Society for your financial support which enabled us to supplement our budgeted funds for delegates to the AMA Auxiliary meeting and to the AMA Auxiliary Confluence in Chicago. The remaining funds are being used to produce and print resource materials. A special thanks to the Medical Society staff for their work and support.

It has been a privilege to serve as president of the Auxiliary, an important arm of the medical society. I hope I can continue to serve you for many years to come.

With your encouragement, I am now seeking the office of State Representative from District 20. I hope, with your support, I can succeed in my endeavors, thereby, opening up another avenue for medicine to seek favorable legislation in Arkansas.

I was honored to receive a check from a physician in the Craighead/Poinsett County Medical Society and from the Craighead/Poinsett County Political Action Committee.

Thank you again for this opportunity to speak to you today.



Address by Mrs. David Williams

1990-91 President-elect

Arkansas Medical Society Auxiliary

Madame Speaker, Dr. Weber, Dr. Jones, House of Delegates:

I bring greetings to you from the members of the Arkansas Medical Society Auxiliary Leadership Confluence being held today. It is indeed a pleasure to talk with you today and know that we in Arkansas are truly accomplishing the goal of our American Medical Auxiliary Association President, Jean Hill, from Mississippi. Mrs. Hill has worked diligently to bring about unity - the oneness in purpose. Unity between county, state, and national medical societies and auxiliaries.

The DWI Project, Phase II, which we are soon to launch statewide, is a classic example of unity. We appreciate the Arkansas Medical Society's support and involvement. We surely would not have attempted and most assuredly could not have moved forward with this tremendous project without you.

At the post-conference board meeting of the Auxiliary, we will begin taking aim with our theme, "Targeting Volunteerism and Building Community Partnerships." Our 1990-91 theme will be extremely important as we garner our energies and approach our four major project areas: Health, Legislation, AMA-ERF, and Membership.

In the area of health, we will be giving special emphasis to adolescent and teen health in possibly five areas: HIV/AIDS, drug and substance use and abuse, teen sexuality, teen suicide, and victimization.

Also, we certainly must not forget children. The National Commission on Children's recent interim report stated that children have become the poorest age group in America, with one in five living below the poverty level. As stated in the report, childhood poverty, more than any other factor, places young Americans at risk for a range of long-term problems, including poor health, failure in school, teenage pregnancy, crime, and drugs.

An article from the Thursday, April 19, 1990, Arkansas Gazette quoted Dr. Robert Fiser, of the Arkansas Children's Hospital, as stating that an average of one baby a day is born with crack or cocaine in its system at University Hospital.

This is an increase from a six a month in 1989 and three a month in 1988.

Our second area of concern is legislation. We are getting organized for the 1991 session of the Arkansas Legislature, and we will be ready to work with Lynn Zeno at his request. We have six auxiliary members as leaders who are energetic and ready to work.

The third area of work involves AMA-ERF. Last year during your assembly, we presented a check of over \$21,000 to the University of Arkansas for Medical Sciences. Our contribution in 1988-89 and 1989-90 have decreased. We urge you to join in partnership with us to increase our Arkansas contributions. An article in the Spring 1990 ARK-MAP quoted the medical school tuition in Arkansas at \$5,720 per year.

The Arkansas Medical Society Auxiliary has converted two of our loan funds, the Martha Harding Gann and Ilse F. Oates, to scholarship funds and will be converting the Brooksher Loan Fund to a scholarship fund shortly. We believe this to be a visionary action.

Our fourth project is membership in the Arkansas Medical Society Auxiliary. We encourage you as medical spouses to remember us when time comes to pay dues.

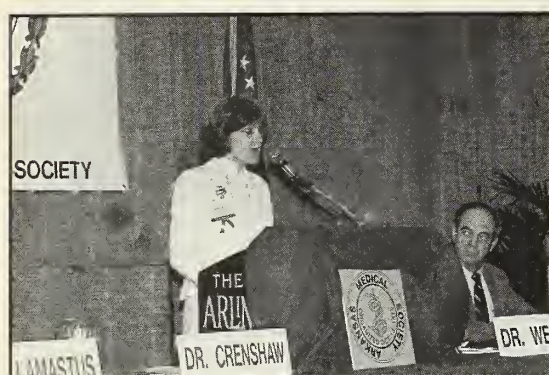
In February 1989 at the Annual Leadership Confluence in Chicago, a keynote speaker, Dr. Carolyn Desjardins, stated that gender differences do exist in the way that we work. She stated that women excelled in projecting enthusiasm and/or strength, optimism, initiative, decisiveness, persuasiveness, and interest in developing people. Men excelled in self-confidence, enjoying a challenge, self-control, involvement in change, and commitment to community service.

My! Has it ever occurred to each of what together we can accomplish?

In 1990-91 as we work to build community partnerships, we must be more visionary in our goals and more powerful in our actions. We ask your support and we pledge to you the strengths that we possess as an auxiliary.

Address by Mrs. William C. Tippens Jr.

American Medical Association Auxiliary
Southern Regional Vice President



Greetings from the 75,000 members of the American Medical Association Auxiliary. Thank you for these few moments to talk about something we believe is vital to the medical community today.

And that is unity...the oneness of purpose and action that enables people collectively to achieve what none of us can do alone.

You have chosen as your motivational philosophy, "Targeting Medicine In The 90's." Many have said the dawn of a new decade is a time for reflecting on the past and predicting the future.

Looking back to more than fifty years ago to an AMA woman's auxiliary meeting in St. Louis, Missouri, Dr. Rock Sleyster, president of the AMA, spoke to the auxiliary House of Delegates. Dr. Sleyster told the auxiliaries, "Being a doctor's wife is both an art and a career. To understand your doctor and his job, you must go back to a time (possibly before you knew him), a time when he made the great decision to give his life to the care of the sick. No ambition for power, or fame, or glory, or riches, prompted him in his choice of a career. Rather, it was his interest in science and his love of service. The highest idealism of youth, motivating him when he determined on the hardest, the longest, and the most expensive preparatory education, to take up a life work, whose main reward is the satisfaction of service well done. It is this idealism, this willingness to sacrifice, this sense of values, which you as his partner must share with him, and must keep alive in him." In 1939, physicians were primarily males, but today quite a lot of physicians are females. The auxiliary is no longer a woman's auxiliary. We have a few male members in the auxiliary and we are working to increase that number. This was Dr. Sleyster's challenge in 1939. But today, never before have challenges to physicians been greater--nor the pressure more intense for those of you in the healing profession.

The 1980's saw physicians assimilate technological advances we only imagined at one time, while the spread of a deadly epidemic resisted the best solutions of medicine's brightest minds. As advances in knowledge enhanced the

power of physicians to defeat disease, government intervention eroded their authority to make decisions about patient care. While physicians achieved levels of healing ability unknown to any earlier generation, physicians found themselves accused of malpractice and blamed for a cooling in the physician-patient relationship. As ethical dilemma called on physicians to be philosophers, economic realities called on them to be businessmen.

But whether the pressures are the result of government intervention or the erosion of patient trust, or ethical dilemmas or professional liability concerns, the challenges must be met with unity in the medical community if they are to work to the good of the patients you serve.

Jean Hill, president of the AMA Auxiliary, has been traveling across the nation urging auxiliaries to join in unity of purpose and action, to help you impact the issues that concern you.

In the past, when we recognized that people need education to make wise health choices, we worked to make them more knowledgeable.

When we realized that concerned citizens must take a stand on legislative issues that affect health, we became involved. When we knew that quality medical education required funding to success, we worked to provide those funds.

Our efforts are no less concerted today. Most recently we have focused on improving the health of the nation's youth. We are working with the AMA, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians to help educate young people about problems such as teen drug abuse, unplanned pregnancy, and now the danger of HIV infection. In the legislative arena, we are working closely with our medical associations, using our phone banks and other legislative contact systems, to help see that you continue your leadership role in ensuring quality health care for your patients.

We also are working to ensure that the physicians of the future, carry on the tradition of quality care you have established. Each year auxiliaries contribute to close to \$2 million to the American Medical Association Education and Research Foundation.

Of course, our ability to achieve our goals is due to our partnership with you. At the 1990 AMA Auxiliary Leadership Conference in Chicago, Alan R. Nelson, M.D., president of the AMA, told the auxiliary members, "I want to talk about our partnership, the mission statement of the AMA is to promote the art and science of medicine and the betterment of public health. The volunteerism that is represented by auxiliaries across the country covers the range of that mission." We must build on that partnership to meet today's challenges. If we join together in a unified effort we will reach the goal we share - a nation in which quality health and health care is in reach of every citizen.

Once again, to paraphrase Dr. Sleyster's remarks, we must work together to keep our aim at the stars, our purpose unchanged, and our ideals in no way lowered. Thank you.

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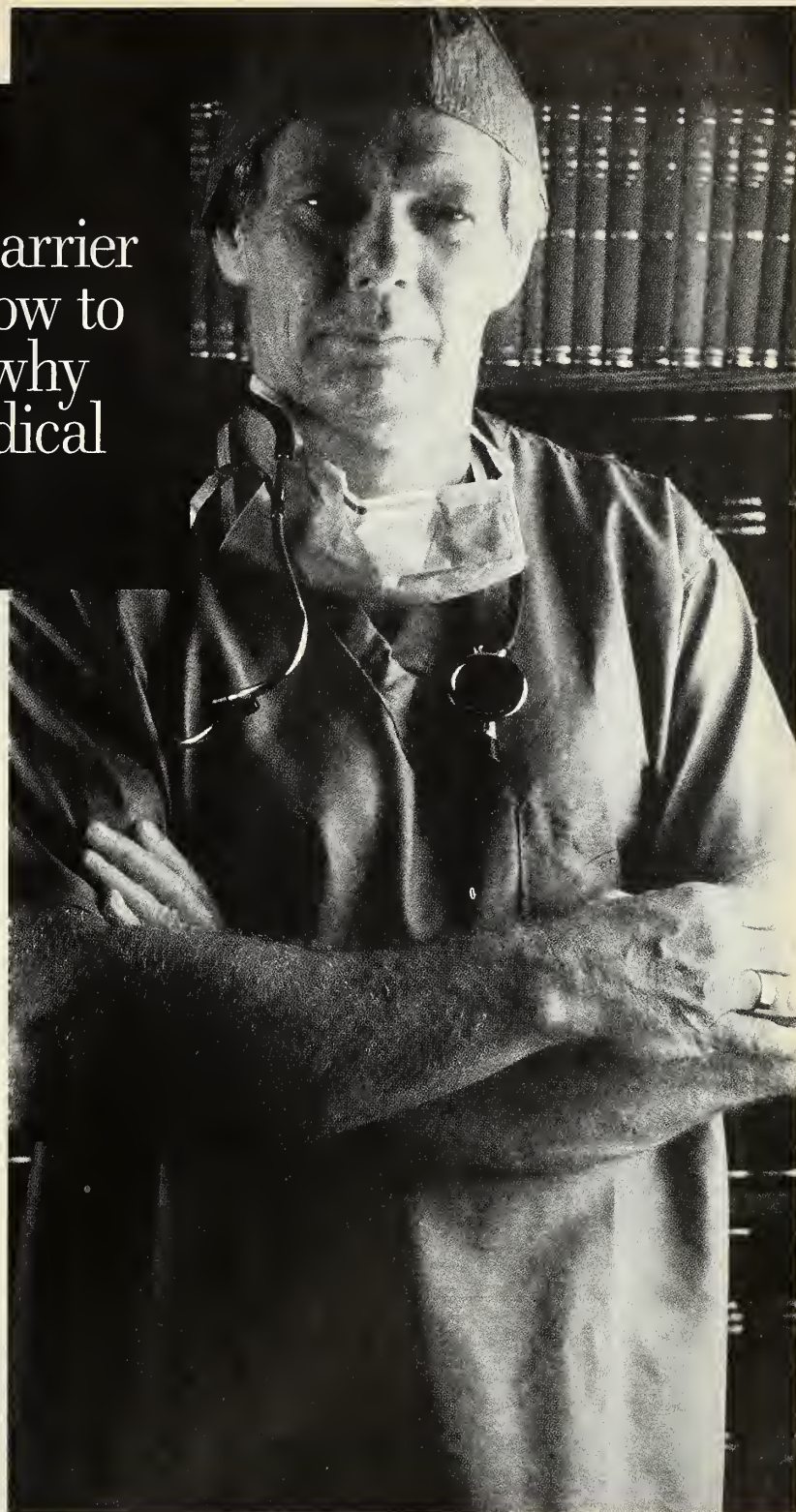
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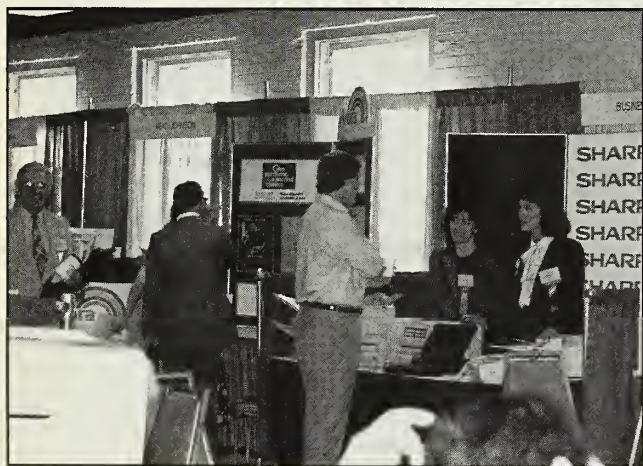
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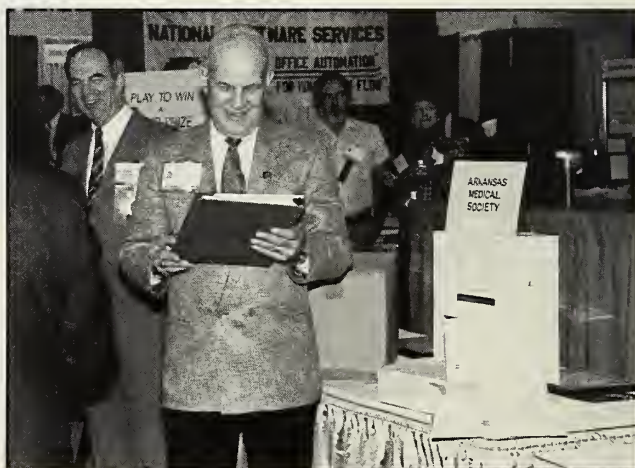
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1990 Scientific Exhibitors

Arkansas Children's Hospital Epilepsy Program; Frederick Boop, M.D., Steve Bates, M.D. and Bernadette Lange, M.D.

Innovations in Orthopaedics; John Slater, M.D., Robert Porter, M.D., Berry Thompson, M.D., Chuck Pearce, M.D. and Phil Delaney.

Laser Treatment of Vascular Lesions; James Y. Suen, M.D. and Milton Waner, M.D.

Percutaneous Removal of Bile Duct Calculi; Steven Teplick, M.D., Pamela Flick, M.D., James Stark, M.D., David L. Harshfield, M.D., Jeffery C. Brandon, M.D. and Contance Brennan.

Plastic and Reconstructive Surgery Procedures; Arkansas Society of Plastic and Reconstructive Surgeons.

Prenatal and Neonatal Sonography of Congenital Urinary Tract Anomalies; Teresita L. Angtuaco, M.D., Stephen F. Miller, M.D. and Ernest J. Ferris, M.D.

Small Fenestra Stapedectomy; Ted Bailey Jr., M.D., James J. Pappas, M.D. and Sharon S. Graham, M.S.

Urinary Incontinence; Pat O'Donnell

Variations in Carotid Endarterectomy Utilization; Gordon W. McCraw, M.D., Robert W. Barnes, M.D., and Donna M. Didier, MEd, RRA.

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In Memoriam

Society Members

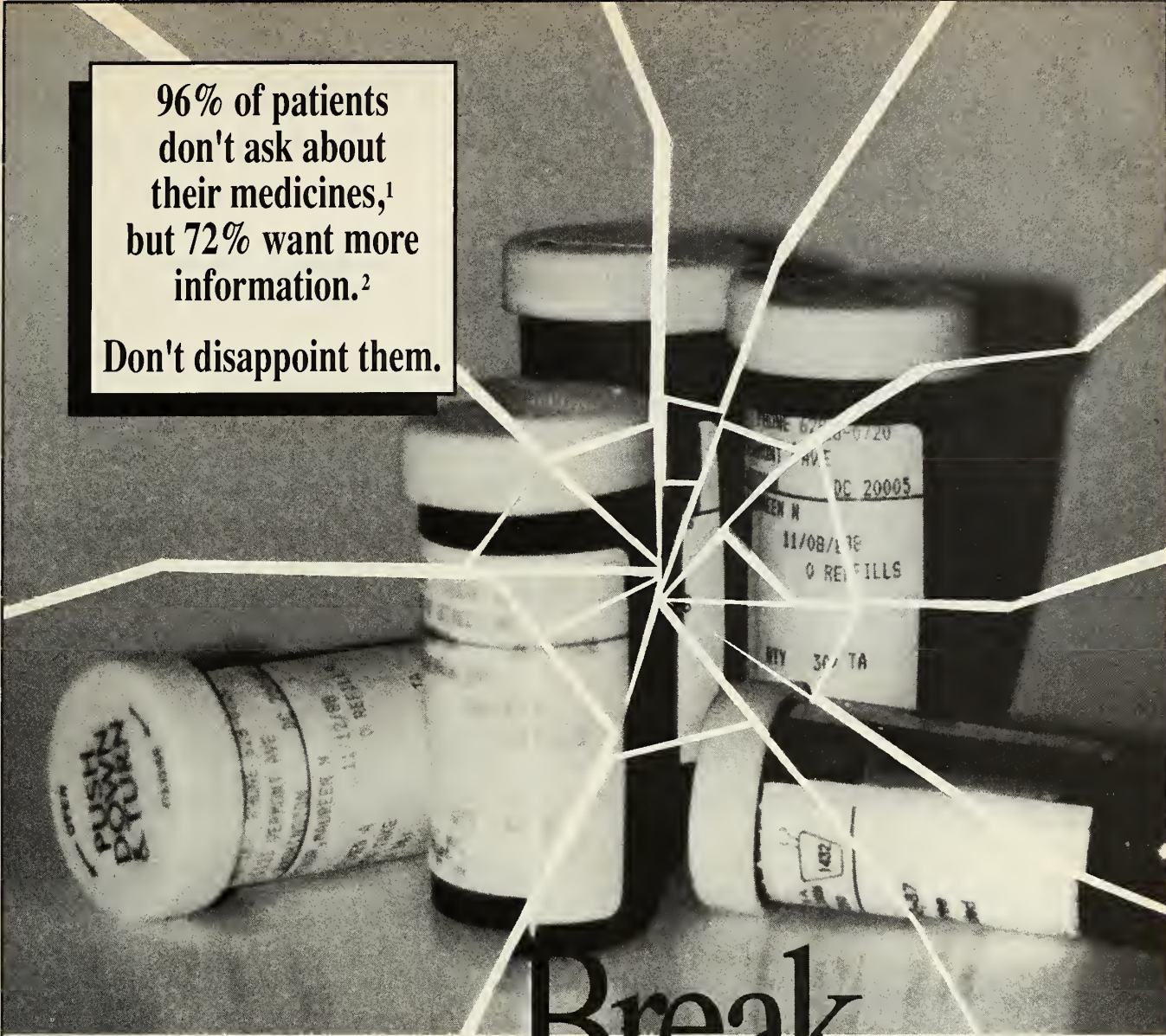
Bob G. Banister, M.D., Conway
Hal R. Black Jr., M.D., Little Rock
Vernon H. Carter, M.D., Elkins
Harold N. Cogburn, M.D., Forrest City
William R. Cothorn, M.D., Memphis, Tennessee
Eva F. Dodge, M.D., Tarboro, North Carolina
James C. Dunbar, M.D., Mountain Home
James W. Durham, M.D., Jacksonville
William Hudson, M.D., Harrison
Jack W. Kennedy, M.D., Arkadelphia
John S. McKinney, M.D., El Dorado
Woodbridge E. Morris, M.D., Little Rock
Monroe B. Painter, M.D., Fayetteville
Ted H. Pye, M.D., Nashville
Edward Safranek, M.D., Fort Smith
Irving J. Spitzberg, M.D., Little Rock
Alvin Strauss, M.D., Little Rock
Ellidee Dotson Thomas, M.D., Fayetteville
H. King Wade, M.D., Hot Springs

Auxiliary Members and Spouses

Mrs. Vernon H. Carter, Elkins
Mrs. Ellis Cope, Little Rock
Mrs. Richard L. Daniel, Little Rock
Mrs. Walter H. Faust, North Little Rock
Mr. Darryl Hiers, Jonesboro
Mrs. Ralph Joseph, Walnut Ridge
Mrs. Blanche P. Langston, Harrison
Mrs. Jerome S. Levy, Fort Collins, Colorado
Mrs. Nicholas Riegler, Little Rock
Mrs. J.M. Robinson, Little Rock
Mrs. Kenneth A. Seifert, Hot Springs
Mrs. William A. Snodgrass Jr., Mobile, Alabama
Mrs. Howard S. Stern, Pine Bluff
Mrs. Frank G. Thibault, El Dorado

96% of patients
don't ask about
their medicines,¹
but 72% want more
information.²

Don't disappoint them.



Break the Rx Silence Barrier

Write for a free "Talk About Prescriptions" Month Guide
containing "how-to" ideas and reproducible patient handouts to:



The National Council on Patient Information and Education
666 11th Street, NW, Suite 810
Washington, D.C. 20001

¹ FDA survey, "Patient Receipt of Rx Drug Information", 1983

² A Study of Attitudes, Concerns, and Information Needs for Rx Drugs
and Related Illnesses, CBS Television Network Consumer Model Survey, 1983

Shuffield Award Winner



Mrs. Louise Richards, of Fort Smith, was presented with the 1990 Shuffield Award by the Arkansas Medical Society. The Shuffield Award is given each year to recognize a non-physician who has made significant contributions to their community in the area of health care.

Mrs. Richards has spent most of her life helping others on both a professional and volunteer basis. She is a retired registered nurse and has worked in a physicians office and as a school nurse for the Fort Smith public schools. She has been deeply involved in SCAN, local hospice programs, and the fight against AIDS. In fact, the local AIDS hotline is in her home. She was one of the first people to volunteer to assist the Vietnamese people in their relocation from Fort Chaffee.

50 Year Club

The 50 Year Club is composed of physicians who, for the past 50 years, have loyally and effectively served the community, and, by skill and devotion to high ideals, upheld and maintained the standards of the medical profession.

Front row: Drs. Aaron C. Modelevsky; Jim McKenzie; John H. Miller; Ben N. Saltzman; John B. Stewart; Henry V. Kirby; Frank G. Thibault Sr.; H.W. Thomas; George H. Wright.

Back row: Drs. John D. Ashley Jr.; Robert H. Atkinson; Max Baldrige; Gilbert O. Dean; Edgar J. Easley; Ross E. Fowler; Edwin Gray; John F. Guenther; James W. Headstream; Alfred Kahn Jr.; Agnes J. Kolb; Albert S. Koenig Jr.



We're Right on Target!

The totals are in....We hit the bull's-eye!
1990 Arkansas Medical Society Annual Convention
Arlington Hotel, Hot Springs
May 3-5, 1990

Physicians	335
Spouses	106
Exhibitors	<u>215</u>
Total attendance	656

1990 Tennis Tournament Players & Winners



Seated: Lucille Cole, 1st Place-Womens Division; Marcia Hixson, M.D., 2nd Place-Womens Division.

Standing: Paul Wallick, M.D.; Dennis Burrow, M.D.; Richard Acklin, M.D.; David Laser; Ed Harper, M.D., 1st Place-Mens Division; Randy Meador, 2nd Place-Mens Division; Robert Borg, M.D.

Serenading the Seniors



Barbershop Triplets!

Performing at the 50 Year Club Luncheon were Drs. Tom May, Robert McGrew, and Sam Welch.

Grand Prize Winner



Fun in Acapulco!

Carlton L. Chambers III, M.D., of Harrison, was the winner of a trip for two to Acapulco. The trip was donated by Tours & Travel of Russellville

AMS Auxiliary Convention Report May 3-5, 1990



Mrs. David Williams
President 1990-91
Arkansas Medical Society Auxiliary

The pre-convention board meeting of the Arkansas Medical Society Auxiliary was held at 2:30 p.m. on Thursday, May 3, with President Nikki Lawson presiding. Discussion and action was taken on issues to be presented to the House of Delegates. Also on Thursday, a pre-convention workshop was conducted by President-elect JoAnn Williams to train and inform 1990-91 board members and county presidents.

On Thursday evening, following a reception honoring past AMS presidents, a silent auction was held to raise funds for AMA-ERF. Items for the auction were contributed from the County Medical Auxiliaries. A total of \$2,888.50 was raised during the evening.

On Friday, May 4, the 66th Annual Session of the

Arkansas Medical Society Auxiliary was called to order at 9:30 a.m. by President Nikki Lawson. The opening was preceded by a seminar on "The Pitfalls of Investments" by Rick Atkins, president, The Arkansas Financial Group, Inc. Special guests for the opening session of the House of Delegates were Dr. James Weber, 1989-90 AMS president; Dr. William N. Jones, president-elect; Dr. Robert E. McAfee, AMA trustee from South Portland, Maine; Ken LaMas-tus, executive vice president of AMS; Peggy Cryer, AMS director of administrative services; Mrs. A.J. Campbell, president, Southern Medical Association Auxiliary; and Mrs. William C. Tippens Jr., AMA Auxiliary southern regional vice president. Mrs. Tippens brought the keynote address, reminding the delegates of a phrase used by President Bush that fits beautifully the Arkansas Auxiliary theme for next year "Targeting Volunteerism and Building Community Partnerships." President Bush said "Volunteerism puts the "unity" in the "community"."

Reports were given by officers and committee chairmen, the 1990-91 budget was presented and adopted, and appreciation was expressed to Mrs. Mary Jo Mizell for serving as finance chairman for the past eight years. Members were informed on the progress of the DWI Project adopted last year and led by Sara Jouett. The main part of it will be a public service announcement contest this September for high school students all over the state urging their peers not to drink and drive. Physicians' spouses will be needed to contact every high school in the state.

The Saturday morning session of the House of Delegates convened following a seminar conducted by former Miss Arkansas, Sharon Ann Evans Bale on "Time Management." Mrs. A.J. Campbell addressed the delegates and urged their participation in Southern Medical Association Auxiliary, inviting them to attend the annual meeting October 14-17, 1990 in Nashville, Tennessee at the Opryland Hotel. County presidents reported on many local Auxiliary activities and new officers were elected for 1990-91: Mrs. David Williams (JoAnn), president; Mrs. Charles Rogers (Rita), president-elect; Mrs. William E. Harrison (Sandy), recording secretary; Mrs. Steve Schoettle (Sue), treasurer; Mrs. Don Vollman (Mary), northeast vice president; Mrs. Robert P. Hughes (Mary Jo), northwest vice president; Mrs. David Jacks (Sandra), southeast vice president; and Mrs. Dale Kincheloe (Bridgette) southwest vice president.

A luncheon at the Belvedere Country Club finalized the 66th Annual Session. Awards were presented as follows: AMA-ERF - Pulaski, Crittenden, Washington, and Arkansas counties; Vinnie Garrison Award - Garland county; Doctor's Day - Jefferson and Craighead/Poinsett counties; and membership - Washington, Baxter and Green/Clay counties. The newly elected officers were installed by national representative Barbara Tippens. President JoAnn Williams presented her inaugural address, outlining her plans for the coming year.

The post-convention board meeting was held immediately following the luncheon with Mrs. Williams presiding.



Look Who's Talkin'



Swearing in the New Officers



Passing Down the Gavel



Presenting the Past President's Plaque



Garland County Welcomes You!



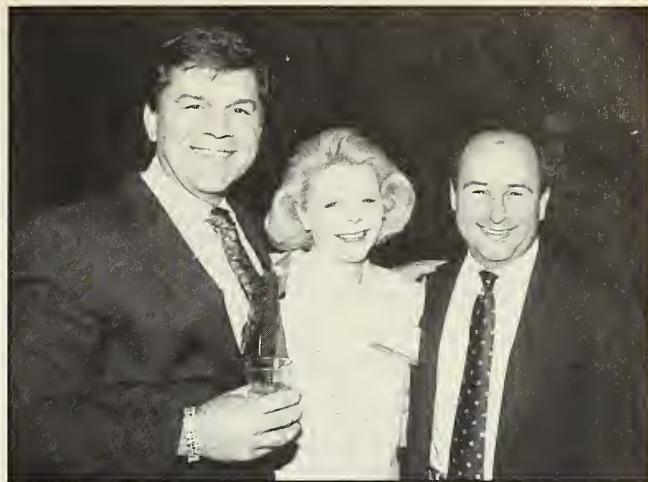
You Ought To Be



Join Us Next Year



In The Pictures, Too!



At The Arlington



Things To Come

June 21-25

The AMA Hospital Medical Staff Section 15th Assembly Meeting. Sponsored by the American Medical Association. Chicago Marriott Hotel in Chicago, IL. For further information, contact the AMA at (312) 645-5000.

June 22-24

Clinical Pediatrics. Presented by Richard J. Summers, M.D. (Allergy); Barton D. Schmitt, M.D. (Behavioral Pediatrics); Sidney Hurwitz, M.D. (Dermatology); William F. Balistreri, M.D. (Gastroenterology); Ellen R. Wald, M.D. (Infectious Diseases); R. James McKay Jr., M.D. (Course Monitor). Sponsored by the American Academy of Pediatrics. Washington, D.C. Fees: \$200, AAP Resident Fellow or allied health professional; \$300, AAP Fellow; \$365, nonmember. For further information call 1 (800) 433-9016.

June 23

Annual Meeting of the Arkansas Oklahoma Endoscopic Society. Double Tree at Lincoln Centre, Dallas, TX. Six hours Category I credit available. For more information, contact Janis at (501) 664-6980.

June 23-26

Summer Executive Symposium. Sponsored by the American College of Physician Executives, Tampa, FL. LeQuatre Saisons, Montreal, Quebec, Canada. CME credit available. For more information, call 1 (800) 562-8088.

July 21-28

8th Annual Medical Seminar. Sponsored by the North Memorial Medical Centre and the University of Minnesota Department of Family Practice. Plummer's Great Slave Lake Lodge, Northwest Territories, Canada. 21 1/2 CME credits available. For more information, call 1 (800) 665-0240.

August 6-10

Physicians in Management I&II. Sponsored by the American College of Physician Executives, Tampa, FL. Four Seasons Hotel, Toronto, Ontario, Canada. CME credit available. For more information, call 1 (800) 562-8088.

August 8-12

3rd Annual Meeting of the Southern Association for Oncology. Sponsored by the Southern Medical Association and the Southern Association for Oncology. Orlando, FL. Fees: \$400 SAO members; \$505 Non-members. Category I credit available. For more information, call 1 (800) 423-4992.

August 30-September 1

Keys to Successful Peripheral Intervention: Balloon, Stent, Atherectomy, and Laser. Sponsored by the Cardiovascular Institute of the South, Houma, LA. Windsor Court Hotel, New Orleans, LA. For more information, contact Jane Arnett at 1 (800) 525-8777.

Keeping Up

43rd Annual Scientific Assembly of the Arkansas Academy of Family Physicians

July 19-22. Presented and sponsored by AAFP. Excelsior Hotel and Statehouse Convention Center, Little Rock, AR. CME credit available. For more information, contact AAFP at (501) 223-2272.

Loss Prevention Seminar

October 20. Co-sponsored by the State Volunteer Mutual Insurance Company and the Arkansas Medical Society. Fayetteville Hilton, Fayetteville, AR. Category I credit available. Free admission. For more information, call 1 (800) 633-3215 or (615) 377-1999.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), third Wednesday, 12:30 p.m., Conference Room, Building 1, VAMC

Mortality/Morbidity Conference, fourth Wednesday, 2:45 p.m., Conference Room, Building 1, VAMC

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Faculty Resident Seminar, third Thursday, 12:00 noon, Sturgis Auditorium

Genetics Conference, Wednesdays, 12:00 noon, Sturgis Building, Room 457

Infectious Disease Conference, second Wednesday, 12:00 noon, 2nd Floor Classroom

Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Building, Auditorium

Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., 2nd Floor Classroom

Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, 2nd Classroom

Pediatric Research Conference, first Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

CARTI Tumor Conference, first Wednesday, 12:00 noon, CARTI Auditorium. Lunch is served.

Cancer Conference, third Thursday, 12:00 noon, Laboratory Conference Room. Lunch is provided.

Hematology-Oncology Conference, second Thursday, 12:00 noon, Laboratory Library. Sandwich buffet served.

Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Southwestern Bell/Arkla Room. Refreshments are provided.

General Medicine Journal Club, Tuesdays, 12:00 noon, Conference Room 1. Lunch is provided.

Pulmonary Conference, second and fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla Room. Sandwich buffet is served.

Surgery Journal Club, Mondays, 12:00 noon, Operating Room Conference Room (2 Northwest). Sandwich buffet served.

Interdisciplinary AIDS Conference, second Friday, 12:00 noon, LaHarpe Room. Sandwich buffet is served.

Peripheral Vascular Disease Conference, first Tuesday, 5:30 p.m., Conference Room 1. Refreshments are provided.

GYN/Oncology Conference, second Monday, 12:00 noon, location to be announced. Lunch provided.

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., Conference Room 1

Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lectures and case presentations. A light lunch is provided.

Pathology Conference, third Tuesday, 3:00 p.m., Pathology Library

Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. A light lunch is provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC/CARTI Tumor Conference, Wednesdays, 12:00 noon, CARTI Auditorium, Markham & University

ACRC Oncology Forum, fourth Thursday, 4:00 p.m., UAMS ACRC 2nd Floor Conference Room, 1.5 credits

Anesthesia Conference Series, Wednesdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B

Anesthesia Morbidity and Mortality Conference, second and fourth Tuesdays, 6:45 a.m.; first, third and fifth Thursdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B

CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy

Child Psychiatry Clinical Case Conference, first Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727

Child Psychiatry Research Review, fourth Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727

Dermatopathology Conference, Tuesdays, 8:00 a.m., UAMS Education Building, Room G/108 A&B

Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Building, Room G/110A&B

Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Building, Room G/110A&B

Emergency Medicine Grand Rounds 1, third Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B

Emergency Medicine Grand Rounds 2, third Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B

Emergency Medicine Morbidity and Mortality Conference, fourth Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B

Emergency Medicine Radiology Conference, fourth Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B

Emergency Medicine Toxicology Conference, first Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B

Emergency Medicine Toxicology Rounds, first Tuesdays 3:00 p.m., UAMS Education Building, Room B/106A&B

GIRadiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology Conference Room, #M1/293.

Interdisciplinary Gynecologic Cancer Conference, Fridays, 12:30 p.m., UAMS Education Building, Room G106 A&B

Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Building, Room G/131A&B

Medicine Research Conference, three Wednesdays per month, 4:30 p.m. Shorey Building, Room 3S06

Neurology Clinical Case Conference, Thursdays, 8:00 a.m. Rotates between UAMS (7D33) and LRVAMC (3S) and ACH

Neuropathology Conference, Thursdays, 10:00 p.m. UAMS Autopsy Room

Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33

Ob/Gyn Grand Rounds, Wednesdays, 8:00 a.m., UAMS Education Building, Room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, Room 3/150, 2 credit hours
Orthopaedic Basic Science Conference, occasional Tuesdays, 11:00 a.m., UAMS Education Bldg., Room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Building, Room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Building, Room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Building, Room B/135
Pathology Autopsy Conference, Mondays, 9:05 a.m., LRVAMC Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
St. Vincent Urology Grand Rounds, first Tuesday, 5:30 p.m., St. Vincent Infirmary, Education Building, Room 159
Surgery Basic Sciences Conference, first Wednesday, 4:00 p.m., UAMS Education Building, Room G/141
Surgery Morbidity and Mortality Conference, Wednesdays, 7:00 a.m., UAMS Education Building, Room G/141A
Surgery Staff/Clinical Case Conference, alternating Tuesdays, 7:00 a.m., UAMS Education Building, Room G/141/
Surgery Review Conference, every second, third and fourth Wednesday, 4:00 p.m., UAMS Education Building, Room G/141
Urology Basic Sciences Conference, second Tuesday, 5:00 p.m., UAMS Education Building, Room G/106A&B
Urology Clinical Didactic Conference, third Tuesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Core Conference, once or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Grand Rounds, second and fourth Tuesday, 5:00 p.m., VAMC-LR (4D)
Urology Morbidity and Mortality Conference, last Wednesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Teaching Conference, one or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Uro-Radiology Workshop (Urologic Imaging), once monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
VA Chest Conference (combined Surgical/Medical Chest Conference), alternating Mondays, 12:15 p.m., VAMC-LR, Room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine Conference Room, Room 1D173
VA Hematopathology Conference, Wednesdays, 3:00 p.m., LRVAMC Conference Room
VA Lung Cancer Conference (combined Medical/Surgical Lung Cancer Conference), Tuesdays, 3:00 p.m., LRVA, Room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Building 68
VA Physical Medicine and Rehab Grand Rounds, fourth Friday, 11:00 a.m., VAMC-NLR Building 68, Room 118 or Arkansas Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, Room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine, Thursdays, 8:00 a.m., VAMC-NLR Building 68, Room 118
VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology Conference Room
Vascular/Radiology Conference, Thursdays, 7:00 a.m., LRVAMC Radiology Conference Room
Vascular Teaching Conference, Thursdays, 8:00 a.m., LRVAMC Radiology Conference Room.

EL DORADO - AHEC

Behavioral Sciences Conference, first and fourth Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, second Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second and fourth Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, fourth Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, first, second and third Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

Cardiology Lecture Series, first Monday, 1:00 p.m., Washington Regional Medical Center
City Hospital Staff Meetings, second Friday, 12:00 noon, Fayetteville City Hospital
Family Medicine Conference, each Tuesday and Wednesday, AHEC - NW, 241 W. Spring, Fayetteville
Internal Medicine Conference, each Tuesday, 12:00 noon, Washington Regional Medical Center

FORT SMITH - AHEC

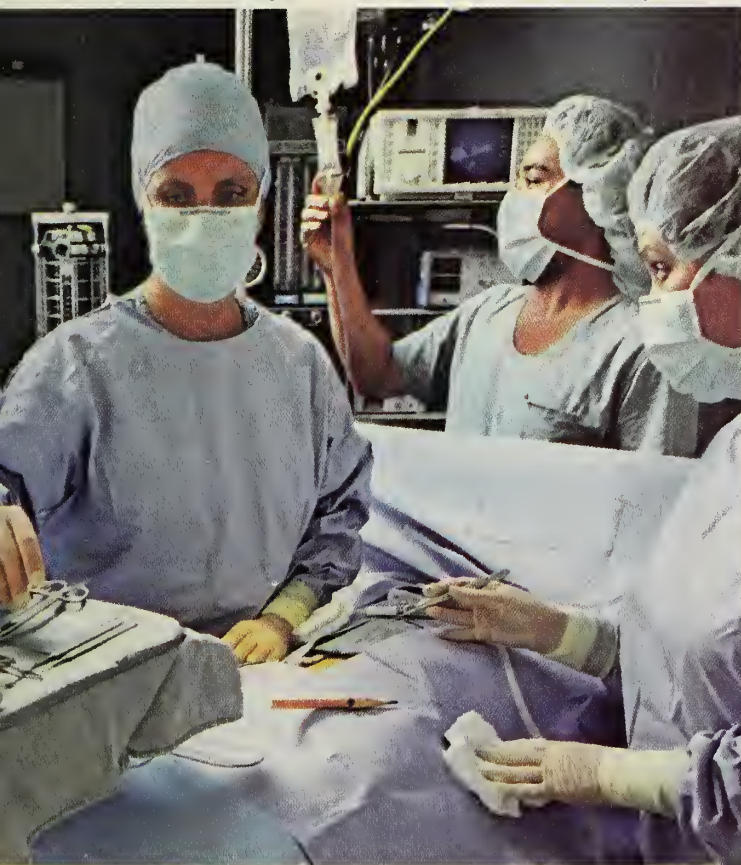
Internal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first and third Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, June 22, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.
Chest Conference, second Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided
Cleburne County Medical Society, second Thursday, 12:00 noon, Cleburne Memorial Hospital - Herbert L. Thomas Conference Room, Heber Springs
Eaker AFB CME Conference, second and third Wednesday, 12:00 noon or 4:00 p.m., Hospital Cafeteria
Independence County Medical Society, second Tuesday, 7:30 p.m., Batesville Country Club, Batesville



Dr. Holwick outside of hospital where she practices as a civilian traumatologist



Dr. Holwick in operating room at Letterman Army Medical Center.

JANN L. HOLWICK, M.D.

General and Trauma Surgeon.
Captain, U.S. Army Reserve.

EDUCATION University of Southern California, B.S.;
University of California School of Medicine.

RESIDENCY Harbor General Hospital—UCLA
Medical Center.

HOSPITAL AFFILIATIONS St. Luke Hospital;
Huntington Memorial Hospital, Pasadena, California;
Traumatologist, Arcadia Methodist Hospital, Arcadia,
California.

OUTSTANDING ACHIEVEMENTS Borden
Freshman Prize; Alpha Lambda Delta; Phi Beta Kappa;
Phi Kappa Phi; Bovard Award; ALD Award; American
Institute of Chemists Medal Award; Summa Cum Laude,
University of California; Alpha Omega Alpha.

“When you enter private practice, the only cases seen are usually those limited to your specialty. Serving as a physician in the Army Reserve offers me a departure from my daily routine. I can be involved in virtually anything I choose. If a certain case interests me, I can ask to be part of the surgical team. If I wish to spend time teaching students, I have that option, too.”

“As a Reserve physician, I’ve had the opportunity to interact with different people, from various backgrounds, with assorted medical and social viewpoints. As a result, I’ve grown as a physician and as a person.”

“I spent six months looking into the Army Reserve program before I joined, wanting to make sure that my skill and time would be put to good use. I’ve been a Reservist three years now, and I still find it extremely rewarding. I have the satisfaction of knowing that I’m serving my country.”

Find out more about the medical opportunities in the Army Reserve. Call toll free 1-800-USA-ARMY.

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BE ALL YOU CAN BE.**

*Because safety
cannot be taken for granted
in H₂-antagonist therapy*

AXID[®]
nizatidine

Minimal potential for drug interactions

*Unlike cimetidine and ranitidine,¹
Axid does not inhibit the cytochrome
P-450 metabolizing enzyme system.²*

Swift and effective H₂-antagonist therapy

- *Most patients experience
pain relief with the first dose³*
- *Heals duodenal ulcer
rapidly and effectively^{4,5}*
- *Dosage for adults with active
duodenal ulcer is 300 mg once nightly
(150 mg b.i.d. is also available)*

References

1. *USP DI Update*, September/October 1988, p 120.
2. *Br J Clin Pharmacol* 1985;20:710-713.
3. *Data on file*, Lilly Research Laboratories.
4. *Scand J Gastroenterol* 1987;22(suppl 136):61-70.
5. *Am J Gastroenterol* 1989;84:769-774.



AXID[®] nizatidine capsules

Brief Summary. Consult the package literature for complete information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to eight weeks of treatment. Most patients heal within four weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than one year are not known.

Contraindication: Known hypersensitivity to the drug. Use with caution in patients with hypersensitivity to other H₂-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlorazepoxide, lorazepam, lidocaine, phenylton, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given

an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H₂-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

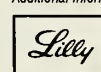
Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

PV 2098 AMP

[091289]

Additional information available to the profession on request.



Eli Lilly and Company
Indianapolis, Indiana
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Interesting Case Conference, fourth and fifth Tuesday, 12:00 noon, St. Bernards Dietary Conference Room. Lunch provided.
Jackson County Medical Society, third Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, third Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, second Tuesday, 7:30 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neurological-Neurosurgical Conference, first Monday, 12:00 noon, St. Bernard's Dietary Conference Room
Neuroradiology Conference, third Friday, 12:00 noon, St. Bernards Dietary Conference Room. Lunch provided.
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Pocahontas CME Conference, third Wednesday, 12:00 noon and 7:30 p.m., Randolph County Medical Center Boardroom
Walnut Ridge CME Conference, third and last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
West Plains CME Conference, fourth Wednesday, 6:30 p.m., West Plains Country Club, West Plains, MO
White River Medical Center CME Conference, June 21, 12:00 noon, Hospital Boardroom

PINE BLUFF-AHEC

Behavioral Science Conference, first and third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second and fourth Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, first and fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, second and fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second and fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Cine Radiology, second Friday, 12:00 noon, Wadley Regional Medical Center.
Echo-Cardiology, fourth Friday, 12:00 noon, Wadley Regional Medical Center
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Neuro-Radiology Conference, first and third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

In Memoriam _____

Harold N. Cogburn, M.D.

Harold N. Cogburn, M.D., of Forrest City, died Monday, March 19, 1990. He was 68.

Dr. Cogburn was a member of the Arkansas Medical Society and the Rotary Club. He was a board member of Harding University, Harding Academy, Harding Graduate School and the First National Bank of Eastern Arkansas. He was also a Navy veteran of World War II.

Dr. Cogburn is survived by his wife, Johanna Cunningham Cogburn; a daughter, Jeanne Wyatt of Oxford, MS; a son, John House Cogburn of Dallas, TX; a sister, Betty Drew of San Antonio, TX; a brother, James Cogburn of Arlington, TX; and six grandchildren.

Winona, MS. - Family Practice, Surgery, Internal Medicine, OB/GYN, Pediatrics. Excellent quality of life, exceptional public school system. Sumner Scholarship Grant for college tuition. Crossroads of I-55 and Highway 82, 88 miles to Jackson, 110 to Memphis. Recruitment package available. Contact Richard Manning, Administrator, Tyler Holmes Memorial Hospital, Tyler Holmes Drive, Winona, MS 38967, (601) 283-4114.

AIDS IN ARKANSAS 1990

January 1 - December 31, 1990

Total number of cases

reported 47

Number of deaths 16

CASES BY SEX

Male 43

Female 4

CASES BY RACE

White 39

Black 8

Other 0

CASES BY RISK GROUP

Homosexual/Bisexual 30

Homosexual & IV Drug User 7

IV Drug User 4

Hemophiliac 0

Transfusion 3

Heterosexual (Contacts) 2

NIR# 1

No identified risk group (NIR)

CASES BY AGE GROUP

Less than 20 1

20 - 29 19

30 - 39 17

40 - 49 9

50 - 59 0

60 or more 1

OPPORTUNISTIC DISEASE

Pneumocystic Carinii 21

Kaposi's Sarcoma 0

Pneumocystis Carinii 0

and Kaposi's Sarcoma 0

Other Diseases 26

AIDS IN ARKANSAS

1985 - 1990

Total number of cases

reported 299

Number of deaths 185

CASES BY SEX

Male 274

Female 25

CASES BY RACE

White 231

Black 66

Other 2

CASES BY RISK GROUP

Homosexual/Bisexual 194

Homosexual & IV Drug User 35

IV Drug User 31

Hemophiliac 2

Transfusion 15

Heterosexual (Contacts) 18

NIR# 4

No identified risk group (NIR)

CASES BY AGE GROUP

Less than 20 4

20 - 29 100

30 - 39 132

40 - 49 42

50 - 59 12

60 or more 9

OPPORTUNISTIC DISEASE

Pneumocystic Carinii 135

Kaposi's Sarcoma 11

Pneumocystis Carinii 6

and Kaposi's Sarcoma 6

Other Diseases 147

Source: Arkansas Department of Health.



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Medicine in the News

Health Care Access Foundation

As of May 1990, the Arkansas Health Care Access Foundation has provided free medical services to 1,330 medically indigent persons.

The program has 1,478 volunteer health care providers including medical doctors, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.

Verification of Licensure for Nurses

The Arkansas Nurse Practice Act is a mandatory law and requires that any person who practices or offers to practice nursing in this state must hold a current Arkansas license or temporary permit.

It is the responsibility of each nurse to keep his/her license current. The Board of Nursing notifies each licensee, by mail to the last address on file, at least 30 days prior to the expiration date of the license.

It is the responsibility of the employer to verify that each nurse he/she employs holds a current Arkansas license or a current Arkansas temporary permit to practice nursing. In addition to other identifying documents you may require, check each nurse's current license before you employ or grant staff privileges to a nurse. Inspect the license for originality (do not accept a photocopy); compare the name and signature of the nurse; check the license number and expiration date. Any changes or alterations on the license should be reported to the board office immediately.

The Board of Nursing staff is too limited to verify the licensure of each employee. The employer's inspection of the license should be sufficient verification and eliminate the necessity of contacting the board office in most instances.

The Board of Nursing recognizes your individual efforts to determine that each nurse in your employ holds a current Arkansas license to practice nursing.

The Parents Club has Successful Fund Raiser

The Parents Club of the University of Arkansas College of Medicine completed a very successful fund raiser. Over \$8,000 in donations were received from physicians throughout the state. A drawing was held at the Capitol rotunda on Monday, April 9, 1990. Jack L. Royal, M.D., a radiologist from Texarkana, held the winning ticket.

The funds will go toward "improving the quality of life style for medical school students" while attending the U of A College of Medicine. Some items approved for purchase were a copying machine, a typewriter, and two

sofas for the Children's Hospital medical student's lounge.

The Parents Club appreciated the support from the physicians, parents, and staff in this united effort on behalf of these dedicated students.

Celebrating Your Ideas

Steve Hanley, a former Arkansas Children's Hospital patient and volunteer, has served Children's Hospital the last seven years as an employee in maintenance, pastoral care, bio-med, and admissions. After working within the hospital in these capacities, Mr. Hanley, who has a B.A. in history from Henderson State University, felt that a thorough history of our institution would be a true asset to both the hospital and the state. He submitted a proposal to Dr. Randall O'Donnell to research and write a complete history of the hospital from 1910 to 1990. The proposal was accepted and Mr. Hanley was appointed the first official historian.

In his quest, Mr. Hanley will interview former physicians, nurses, patients, parents, volunteers, and others whose eye-witness accounts date as early as the 1920's.

Mr. Hanley is avidly seeking the historical puzzle pieces to reconstruct the historical roots of Arkansas Children's Hospital. If anyone has written records or information to share with him, please write to Mr. Hanley at Arkansas Children's Hospital, 800 Marshall St., Little Rock, AR 72201, or call 370-3656.

Testing Helps Infant Survival

The chances for survival of infants in Arkansas and across the U.S. have improved dramatically in the last several years, and part of the reason for these lives being saved in prenatal testing, according to Dr. Judy McDonald, an obstetrician on the medical staff at Doctor's Hospital.

Just a few years ago the infant mortality rate in pregnant women was about 20 in a thousand. The Arkansas State Health Department's latest statistics in 1988 indicate Arkansas has an infant mortality rate of 10.7 per thousand with the national average slightly less at 9.9 per thousand.

While many factors have contributed to the decline in infant mortality - better equipment, transportation and neonatal intensive care units - prenatal testing a primary factor that women don't always consider.

"Sometimes testing can prevent prematurity by spotting a condition that may result in early labor," Dr. McDonald explains. "The discovery gives doctors time to either correct the problem or put the woman on a regimen that may include bed rest to postpone the delivery."

Prenatal testing cannot cut down on birth defects, she points out, but it can detect them early so that parents are

warned before the birth, allowing them time to absorb the news. The information alerts doctors who can plan the best course of action once the baby is born.

Physician Reimbursement

An amendment to **Pennsylvania's** State Vehicle Code was enacted February 7, 1990, as part of a comprehensive auto insurance reform law. The amendment caps fees for physicians treating auto accident victims at 110% of Medicare levels, effective April 15, 1990.

Contributions to Arkansas Medical History

The History of Medicine Associates of the UAMS Library, with assistance from the Arkansas Endowment for the Humanities, has recently published *Contributions to Arkansas Medical History*. The papers included are the

winners of the first five History of Medicine Associates Research Awards. Each of the papers provides information about a different aspect of Arkansas health care.

Copies of the book are available, prepaid only, from:

History of Medicine Associates
c/o Special Collections
UAMS Library, Slot 586
4301 West Markham
Little Rock, AR 72205-7186

The cost of the book is \$15.00 plus a \$2.00 postage and handling fee. There is a special price for associate members.

The History of Medicine Associates is a support group for the Special Collections Division of the UAMS Library which includes historical books, photographs, and archival materials.

AMS NewsMakers

Murl Baker, M.D., of the Springdale Ear, Nose, Throat and Hearing Clinic, has joined the Northwest Arkansas Radiation Therapy Institute Physician Advisory Board.

Vida H. Gordon, M.D., of Little Rock, has been selected as a "Distinguished Alumnus" from her alma

mater - Rush Medical College in Chicago.

Larry D. Wright, M.D., of Rogers, has been elected to fellowship status in the American Geriatrics Society (AGS). Dr. Wright is medical director of the Geriatric Assessment Clinic and of geriatric services for St. Mary-Rogers Memorial Hospital.

New Members

BOONE COUNTY

Hutcheson, Galen W., Family Practice, Harrison. Born March 6, 1948, Alice, TX. Pre-medical education, Arkansas Tech University, 1981. Medical education, UAMS, 1986. Internship/residency, AHEC - Northeast (Jonesboro). Board certified. Member, American Society of Family Practitioners, American Medical Society.

CRAIGHEAD/POINSETT COUNTY

Degges, Russell D., General Surgeon, Jonesboro. Born March 28, 1957, Warren. Pre-medical education, University of Central Arkansas, 1978. Medical education, UAMS, 1983. Internship/residency, UAMS, 1988. Practice experience, 1 1/2 years. Board certified.

FAULKNER COUNTY

Ghormley, Jonathan T., Orthopaedics, Conway. Born September 25, 1954, Amarillo, TX. Pre-medical education, University of Houston, TX. Medical education, University of Texas Medical Branch, Galveston, TX, 1984. Internship/residency, Texas Tech Health Science Center, Lubbock, TX, 1989. Board eligible.

GARLAND COUNTY

Ward, David G., Pediatrics, Hot Springs. Born August 29, 1951, Midland, TX. Pre-medical education, University of Houston, 1980. Medical education, Baylor College of Medicine, Houston, TX, 1983. Internship, RS Thomason General Hospital, El Paso, TX, 1984. Resi-

gency, Texas Childrens Hospital, Houston, 1985; Baylor Affiliated Hospitals, Houston, 1987. Military, USMC, 1971-75. Member, American Academy of Pediatrics, ACEP. Board eligible.

INDEPENDENCE COUNTY

Alexander, William S., General Surgery, Batesville. Born March 19, 1951, Flint, MI. Pre-medical education, University of Arkansas, Fayetteville, 1979. Medical education, UAMS, 1983. Internship/residency, University of Tennessee Center for Health Sciences, Memphis, 1988. Military, US Army Special Forces, 1973-76. Board certified.

MONROE COUNTY

Collins, Linda F., General Practice, Brinkley. Born October 24, 1952, Parkin. Pre-medical education, LeMoyné-Owne College, 1974. Medical education, UAMS, 1980. Internship, UAMS, 1981. Practice experience, 8 years.

POPE COUNTY

Bell, Michael F., General Surgery, Russellville. Born March 4, 1955, Memphis, TN. Pre-medical education, University of Arkansas, Little Rock, 1977. Medical education, University of Arkansas, 1982. Internship, Ohio Valley Medical Center, Wheeling, WV. Residency, Wesley Medical Center, Wichita, KS. Practice experience, 1 1/2 years. Board eligible.

PULASKI COUNTY

Cosgroave, Lisa A., Pediatrics, Little Rock. Born November 25, 1954, Little Rock. Pre-medical education, University of Miami, 1975. Medical education, Ross University School of Medicine, Portsmouth, Dominica, 1984. Internship/residency, Emory University, 1987. Practice experience, 3 years. Board certified. Member, American Board of Pediatrics.

SALINE COUNTY

Moore, Thomas C., Family Practice, Bryant. Born May 25, 1954, Little Rock. Pre-medical education, Hendrix College, Conway, 1974; UALR, 1981. Medical education, UAMS, 1985. Internship/residency, UAMS, 1989. Board eligible.

SEBASTIAN COUNTY

Hanley, Larry L., Family Practice, Fort Smith. Born September 30, 1935. Pre-medical education, Indiana University, 1957. Medical education, Indiana University School of Medicine, Indianapolis, 1960. Internship/residency, Methodist Hospital, Indianapolis, 1961. Practice experience, 28 years. Board certified. Member, AAFP.

Hendrickson, Kathryn D., Pediatrics, Fort Smith. Born October 6, 1952, Hillsboro, KS. Pre-medical education, Tabor College, 1974. Medical education, University of Kansas, 1977. Residency, Children's Mercy Hospital, Kansas City, MO. Practice experience, 8 years. Board certified. Member, American Academy of Pediatrics.

Henry, James T., Internal Medicine/Nephrology, Fort Smith. Born June 24, 1958, Fort Smith. Pre-medical education, University of Arkansas, Fayetteville, 1980. Medical education, UAMS, 1984. Internship/residency, University Hospital/McClellan VA, Little Rock. Board certified. Member, American College of Physicians.

McClanahan, John D., OB/GYN, Fort Smith. Born June 1, 1956, Louisville, KY. Pre-medical education, Ouachita Baptist University, 1978; U of A, Fayetteville, 1978. Medical education, U of A, 1984. Internship/residency, John Peter Smith Hospital, Fort Worth, TX. AAGL, GLS, AFS, Junior Fellow American College of Obstetrics & Gynecology.

TRI-COUNTY

Wright, Donald O., Family Practice, Calico Rock. Born June 6, 1952, El Paso, TX. Pre-medical education, US Air Force Academy, 1974; East Texas State University, 1982. Medical education, University of Texas Medical Branch, Galveston, TX, 1986. Internship/residency, John Peter Smith Hospital, Fort Worth, TX. Military, USAF, 1970-80.

WASHINGTON COUNTY

Bredfeldt, Raymond C., Family Practice, Fayetteville. Born May 22, 1951, Oak Park, IL. Pre-medical education, University of Illinois, 1974. Medical education, Georgetown University, 1978. Board certified. Practice experience, 9 years. Member, ABFP, AAFP.

Harper, Richard A., Ophthalmology, Fayetteville. Born May 20, 1958, Oklahoma City, OK. Pre-medical education, University of Oklahoma, 1980. Medical education, University of Oklahoma College of Medicine, 1984. Internship/residency, UAMS, 1989. Member, American Academy of Ophthalmology.

RESIDENT SECTION

Mirza, Muhammed Hussain. Born March 10, 1942, Pakistan. Pre-medical education, Federal College Karachi, 1966; University of Karachi, 1973. Medical education, Universidad Nordestana San Francisco, De Macoris Republic Dominican, 1981. Internship/residency, Harlem Hospital, New York, NY, 1989.

Washburn, Tonya C., Physical Medicine and Rehabilitation, Little Rock. Born August 10, 1963, Tulsa, OK. Pre-medical education, University of Oklahoma, Norman, 1984. Medical education, University of Oklahoma, Oklahoma City, 1988. Internship/residency, UAMS.



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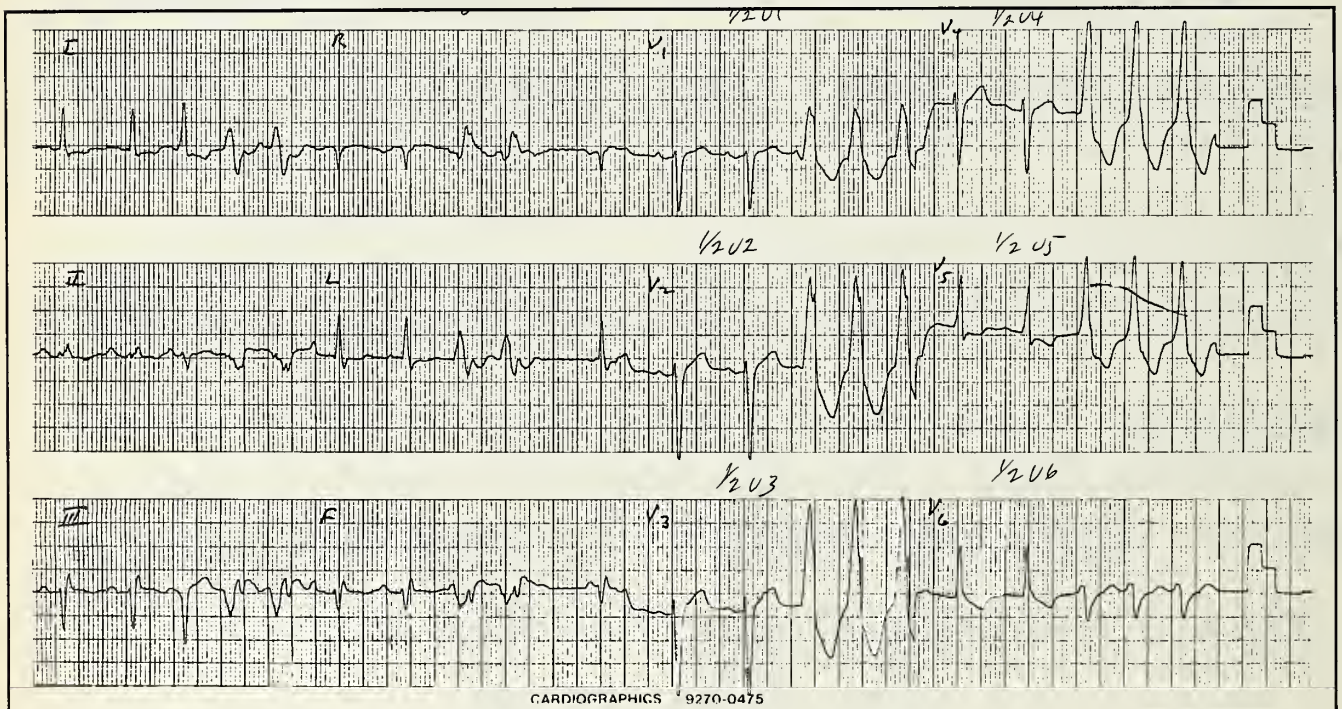
ELECTROCARDIOGRAM of the MONTH



G.T. Gray, O.D.
John W. Watson, M.D.

CLINICAL HISTORY:

T.P. is a 48-year-old coach who developed angina which was ultimately treated with angioplasty. Later, he was found to have ectopic ventricular contractions which were treated with an antiarrhythmic agent. Shortly thereafter, the patient experienced syncope. His physical examination on admission was normal except for an irregular irregularity of the heart rate. What do you think of the admission electrocardiogram



DISCUSSION:

The basic mechanism is sinus. Nonspecific ST-T changes are noted. Wide QRS complex beats are present and are paired and in runs of three. The third beat on the strip is probably a fusion beat. The patient thus has documentation of what is most likely nonsustained ventricular tachycardia. This could well represent a proarrhythmic property of his antiarrhythmic agent.

The editor wishes to thank Dr. Gray of Conway for his assistance with this month's featured electrocardiogram.

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Family Physician - Fifth FP sought to join progressive 20 man multi-specialty group in historic Midwest community. Fully equipped 120 bed hospital with plans for new facility, excellent school system, many recreational and civic activities. competitive starting salary and benefits package with productivity, bonus and partnership potential. Full range of sub-specialists available. Call Cheryl Broderick, E.G. Todd Associates, (800) 762-9213 or collect (508) 688-9063.

Internist - Third internist to join very busy progressive 20 man multi-specialty group in historic Midwest community. Fully equipped 120 bed hospital with plans for new facility, excellent school system, many recreational and civic activities. Competitive starting salary and benefits package with productivity bonus and partnership potential. Call Cheryl Broderick, E.G. Todd Associates, (800) 762-9213 or collect (508) 688-9063.

OB/GYN - Fourth OB/GYN to join very busy 20 man multi-specialty group in a historic Midwestern town. Birthing rooms and 24 hour anesthesia availability. Fully equipped 120 bed hospital, many recreational and civic activities. Competitive starting salary and benefits package with productivity bonus and partnership potential. Call Cheryl Broderick, E.G. Todd Associates, (800) 762-9213 or collect (508) 688-9063.

Orthopedic Surgeon - Second orthopedic surgeon sought to join very busy 20 man multi-specialty group in Midwest community. Interest in back surgery a plus. Fully equipped professionally staffed P.T. department at 120 bed hospital; excellent school system, many recreational and civic activities. Competitive starting salary and benefits package with productivity bonus and partnership potential. Call Cheryl Broderick, E.G. Todd Associates, (800) 762-9213 or collect (508) 688-9063.

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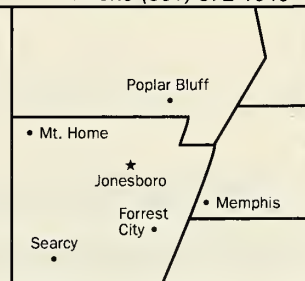
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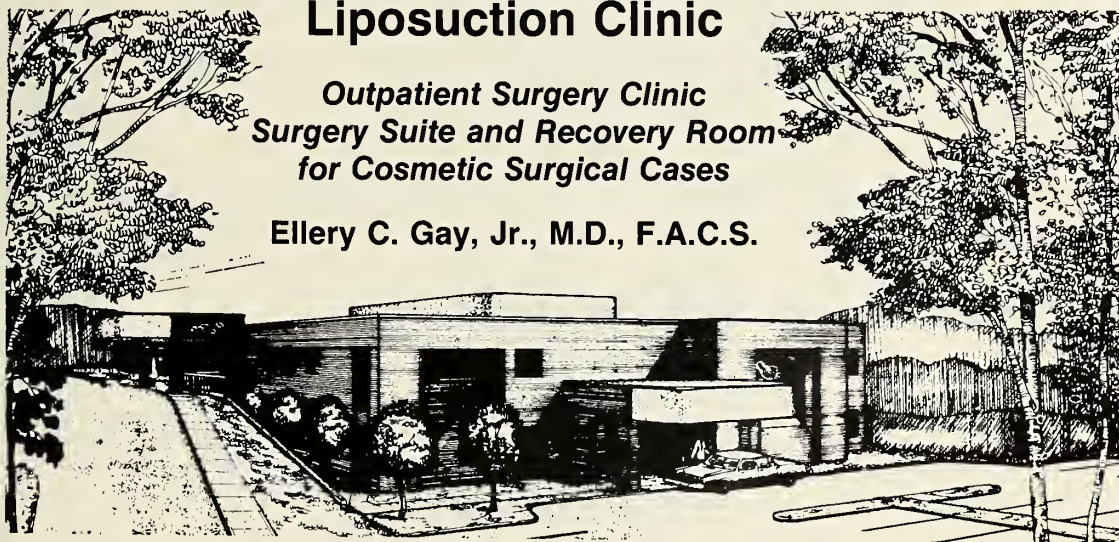
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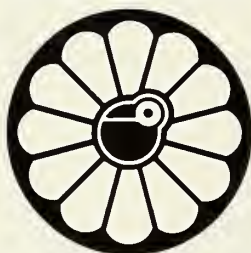
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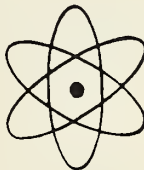
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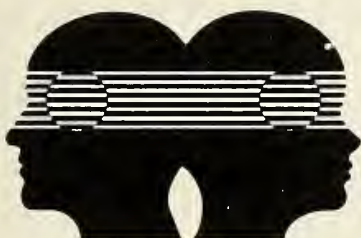
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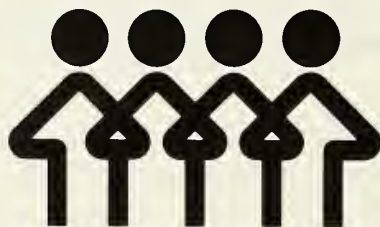
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VASOTEC®

(ENALAPRIL MALEATE) MSD

VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: **Angioedema:** Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypertension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, Drug Interactions and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: **General:** **Impaired Renal Function:** As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (>5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See Drug Interactions.)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypertension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyl-dopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy—Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters. There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not

been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers: Milk in lactating rats contains radioactively following administration of ¹⁴C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, Hypertension); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances; atrial fibrillation; palpitation.

Digestive: Ileus, pancreatitis, hepatitis (hepatocellular or cholestatic jaundice), melena, anorexia, dyspepsia, constipation, glossitis, stomatitis, dry mouth.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, hyperhidrosis.

Special Senses: Blurred vision, taste alteration, anosmia, tinnitus, conjunctivitis, dry eyes, hearing.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgias/arthritis, myalgias, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings:

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: **Hypertension:** In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance > 30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤ 30 mL/min (serum creatinine ≥ 3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, Pharmacodynamics and Clinical Effects.) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

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House of Delegates Approves New Constitution and Bylaws

The following revisions were passed by the AMS House of Delegates on May 5, 1990. Current rules require that these revisions be published twice during the year and then voted on again at the 1991 Annual Session, before becoming effective. This is the first publication.

New language is identified by "italics"; language to be deleted is struck through.

Constitution and Bylaws of the Arkansas Medical Society (Mark-Up, 1990)

CONSTITUTION

ARTICLE I. Name of Society

The name of this organization shall be the Arkansas Medical Society.

ARTICLE II. Purposes of the Society

The purposes of this Society shall be:

1. To federate and bring into one compact organization the entire medical profession of the State of Arkansas and to unite with similar societies of other states to form the American Medical Association;
2. To extend medical knowledge and advance medical science;
3. To elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws;
4. To promote friendly intercourse among physicians;
5. To guard and foster the material interests of its members and to protect them against imposition;
6. To enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life; and
7. To maintain medical ethics and to secure compliance with the art and science of medical practice.

ARTICLE III. Component Societies

Component societies shall consist of those societies which hold charters from this Society as provided in the Bylaws.

~~ARTICLE IV. Composition of the Society~~

~~Section 1. Composition~~

~~This society shall consist of members, delegates and guests:~~

~~Section 2. Members~~

~~The membership of this Society shall comprise all the members of its component societies:~~

~~Section 3. Delegates~~

~~Delegates shall be those members who are elected or seated in accordance with the Constitution and Bylaws to represent their respective component societies in the House of Delegates of this Society:~~

~~Section 4. Guests~~

~~Any distinguished physician not a resident of this State, who is a member of his own state society, may become a guest during any annual session on invitation of the officers of this Society, and shall be accorded the privilege of participating in all of the scientific work for this session:~~

ARTICLE IV. *Members (New)*

The Arkansas Medical Society is composed of individual members of its component societies and others as may be provided for in the Bylaws.

ARTICLE V. Sections and District Societies (Old Art. VII)

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of ~~component societies: this Society.~~

~~ARTICLE VI. House of Delegates~~

~~The House of Delegates shall be the legislative body of the Society, and shall consist of (1) delegates elected by the component societies or seated by the House of Delegates to represent component societies as provided in the Bylaws; (2) the councilors, and (3) ex-officio, the President, First Vice President, President-elect, Speaker, Vice Speaker, Secretary, Treasurer, and past presidents of the Society; provided, however, that the ex-officio members shall have the power of voting on all subjects except the election of officers. (Trans. to Ch. IV, Sec. 6, Bylaws)~~

The House of Delegates shall be the legislative and policy-making body of the Society composed of members

elected by the component societies and others as provided in the Bylaws. The House of Delegates shall transact all business of the Society not otherwise provided for in this Constitution and Bylaws and shall elect the general officers except as may be provided in the Bylaws.

ARTICLE VI Council (Moved to ARTICLE VIII)

ARTICLE VII. General Officers (Prev. Art. IX)

The officers of this Society shall be a president, president-elect, ~~three vice presidents~~, vice president, Speaker of the House of Delegates, Vice Speaker of the House of Delegates, a secretary, a treasurer, an immediate past president, and councilors. Their qualifications and terms of office shall be as provided in the Bylaws.

ARTICLE ~~VI~~ VIII Council (Sec. 2 & 3 moved to CH. VII)

Section 1. Duties

The Council shall be the executive body of the House of Delegates and between sessions of the House shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws. It shall constitute the Finance Committee of the House of Delegates.

Section 2. Composition

The Council shall consist of the councilors, the president, first vice president, president-elect, secretary, treasurer, and immediate past president, and the Speaker of the House of Delegates. The Vice Speaker of the House of Delegates, and the Delegates and Alternate Delegates to the American Medical Association shall be members ex-officio without vote. The Speaker and Vice Speaker of the House of Delegates and the past presidents shall be members ex-officio without vote, except that the Immediate Past President shall have a vote. There shall be two councilors from each district which has two hundred members or less. In districts where there are more than two hundred members, there shall be an additional councilor for each additional one hundred members. The councilors shall serve staggered terms of two years each. All councilors shall have equal voting privileges. A majority of the voting members shall constitute a quorum.

Section 3. Representation

Representation on the Council shall be based upon the enumeration of members in each councilor district in accordance with provisions of these Bylaws for representation in the House of Delegates.

Section 4 3. Executive Committee

The Chairman of the Council, the president, the president-elect, the secretary, the treasurer, and the immediate past president shall constitute the Executive Committee of the Council. The Chairman of the Council shall serve as Chairman of the Executive Committee. The Executive Committee shall have such powers and duties as provided in the Bylaws and as may be defined from time to time by resolution of the Council.

ARTICLE ~~VIII~~ IX Sessions and Meetings

Section 1:

The Society shall hold an Annual Session, during which there shall be held daily general meetings, which shall be open to all registered members and guests.

Section 2:

The place and time for holding each Annual Session shall be decided by the Council.

The Society shall hold a meeting of the House of Delegates at least annually and at other times as deemed necessary or as provided in the Bylaws. The place and time for holding each meeting shall be determined by the Council.

ARTICLE X. Funds and Expenses, Dues and Assessments

Section 1:

Funds shall be raise by an equal per capita assessment on each component society except as provided in the Bylaws. The amount of the assessment shall be fixed by the House of Delegates on four-fifths vote of the delegates present.

Section 2:

Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. Funds may be appropriated by the House of Delegates to defray the expenses of the Society for publications, and for such other purposes as will promote the welfare of the profession. All resolutions appropriating funds must be referred to the Council before action is taken thereon.

Funds may be raised by annual dues, or assessments, on the members of the Society except as provided in the Bylaws. The amount of dues or assessments shall be fixed by the House of Delegates on four-fifths vote of the delegates present, provided that a written notice has been sent to all dues paying members at least 90 days prior to the House of Delegates meeting. Funds may also be raised from voluntary contributions, society publications and services. All resolutions appropriating funds must be referred to the Council before action is taken thereon.

ARTICLE XI. Referendum

Section 1:

A general meeting of the Society The House of Delegates may, by a two-thirds vote, of the members present, order a general referendum on any questions pending before the House of Delegates it, and when so ordered the House of Delegates shall submit such questions to the members of the Society, who may vote by mail or in person. If the members voting shall comprise a majority of all the members of the Society, a majority of such vote shall determine the question and be binding upon the House of Delegates.

Section 2:

The House of Delegates may, by a two-thirds vote of its own members, submit any questions before it to a general referendum, as provided in the preceding section;

and the result shall be binding upon the House of Delegates.

ARTICLE XII. The Seal

The Society shall have a common seal, with power to break, change or renew the same at pleasure, by action of the House of Delegates.

ARTICLE XIII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any annual session, ~~provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in a bulletin or journal of this Society.~~ *meeting of the House of Delegates, provided that the amendment shall have been mailed to all members at least 90 days prior to the meeting.*

BYLAWS

CHAPTER I. Membership

~~Section 1. Membership in Component Societies~~

- ~~(A) Membership in this Society shall be by membership in one of its component societies.~~
- ~~(B) The name of a physician on the properly certified roster of members of a component society which has paid its annual assessment shall be prima facie evidence of membership in this Society.~~

Section 1. General Requirements for Membership

A person seeking application to this Society must fulfill at least one of the following requirements:

- (A) Possess the degree of Doctor of Medicine or Osteopathy AND hold a license to practice medicine and surgery issued by the Arkansas State Medical Board; (B) Are Intern/Residents serving in an approved training program in this state; or (C) Are Medical Students enrolled in an approved medical school in this state.*

Any person when becoming a member shall agree to abide by the Constitution and Bylaws of this Society and by any changes which from time-to-time may be made. The member further agrees to abide by the Principles of Medical Ethics of the American Medical Association.

~~Section 2. Membership Classifications~~

Section 2. Membership Categories

Categories of membership are: A. Active; B. Active Direct; C. Life; D. Emeritus; E. Affiliate; F. Associate.

(A) Active Membership

~~The active membership of this Society shall be comprised of all the active members of its component societies. Only such person is eligible for active membership in a component society as possesses the degree of Doctor of Medicine or Doctor of Osteopathy and holds an unrevoked license to practice medicine and surgery issued by the Arkansas State Medical Board. The eligibil-~~

~~ity requirements set forth in the preceding sentences are not to apply, however, to the members of the specially chartered "Student and Intern and Resident Societies."~~

(A) Active

Active members are members of component societies who are entitled to exercise the rights of membership in their component society. A person eligible for Active membership shall become a member of this Society upon certification by the secretary of the component society to the Arkansas Medical Society Executive Vice President that the person meets the requirements for membership in Chapter I, Section 1, of these Bylaws. Intern/residents and medical students shall be entitled to the same rights and privileges accorded other members except that they shall not hold office or chair committees.

(B) Active Direct

Active Direct members are those who apply for membership in this Society directly rather than through a component society. Intern/residents and medical students shall not be eligible for this category.

- (1) Active Direct members are admitted to membership upon application to the Executive Vice President and after approval by the Executive Committee of the Arkansas Medical Society. When reviewing applicants for Direct membership, the Executive Committee shall establish that the applicant meets the requirements of membership as outlined in Chapter I, Section 1, of these Bylaws and may consider information pertaining to the character and ethics of the applicant. The Committee shall provide by rule for an appropriate hearing procedure to be provided to the applicant.*

- (2) The Arkansas Medical Society shall immediately notify the secretary of each component society of the name and address of those applicants for Active Direct membership residing within its jurisdiction.*

- (3) Objections to applicants for Active Direct membership must be received by the Executive Vice President within 30 days of receipt by the component society of the notification of application. Any objections will be referred to the Executive Committee of the Arkansas Medical Society for disposition.*

- (4) Active Direct members shall have the right to vote, hold office, and all other privileges of membership in this Society.*

(B) (C) Life Membership

A physician who has been an Active or Active Direct member of this Society for a period of ten

years and who has continuously been a member of organized medicine and has either (1) attained age seventy or (2) practiced forty-five years shall be eligible for life membership. ~~and, upon the recommendation of his component society, shall be granted such status by the House of Delegates. Such status shall be granted by the House of Delegates upon the recommendation of the members' component society or, in the case of an Active Direct member, the Executive Committee of the Arkansas Medical Society.~~ Life members shall have the right to vote, hold office, and all other privileges of membership in this Society.

(C) ~~(D)~~ Emeritus Membership

A physician who has been an *Active or Active Direct* member of this Society for a period of ten years and who has continuously been a member of organized medicine for less than forty-five years and who has fully retired from the practice of medicine shall be eligible for emeritus membership. ~~Such membership shall be granted by the House of Delegates upon the recommendation of the member's component society. Such status shall be granted by the House of Delegates upon the recommendation of the members' component society or, in the case of an Active Direct member, the Executive Committee of the Arkansas Medical Society.~~ Emeritus members shall have the right to vote, hold office, and all other privileges of membership in this Society. *Emeritus members shall be entitled to all privileges of this Society except that they shall not hold office.*

(D) ~~(E)~~ Affiliate Membership

An *Active or Active Direct* member in good standing in his component society may be granted affiliate membership where one or more of the following conditions exists: physical or other disability of a character preventing the practice of medicine, a serious and prolonged illness, financial reverses, or *service in the armed forces of the United States, not as a career officer.* Affiliate membership shall be on an annual basis only and ~~a member~~ must be recommended each year for such special status by ~~his the member's~~ component society *or, if an Active Direct member, the Arkansas Medical Society Executive Committee* following a review and reassessment of ~~his the~~ particular situation. An Affiliate members shall enjoy full membership privileges except that ~~he~~ they shall not have the right to vote or hold office.

(E) ~~(F)~~ Military Members

~~An active member in good standing in his component society who enters the service of the armed forces of the United States, not as a career~~

~~officer, may be classified as a military member, and carried on the roll of his component society as such.~~

~~A physician entering service of the armed forces of the United States, not as a career officer, upon completion of internship or residency training shall be eligible for military membership upon the request of a component society.~~

~~Military members shall enjoy full membership privileges except that they shall not have the right to vote or hold office.~~

(F) Associate Members

Physicians who are licensed to practice medicine and surgery in this State as well as an adjacent state and are engaged in the delivery of health services in both states may become associate members of this Society provided they are active members of the state medical association in the adjoining state. Associate members may vote as provided in this Constitution and Bylaws and may serve on all committees, but shall not hold office.

(G) Intern and Resident Members

~~Physicians licensed to practice medicine and surgery in this State who are engaged in filling intern or residency appointments in approved hospitals shall be eligible for membership in this Society. Such membership shall end with termination of this status. Such members shall enjoy the rights and privileges accorded active members except that they shall not hold office or chair committees.~~

(H) Student Members

~~Students enrolled in an approved medical school shall be eligible for student membership in this Society. Student members shall enjoy the rights and privileges accorded active members except that they shall not hold office or chair committees.~~

Section 3. Dues Exemption

(A) Life, emeritus, affiliate, ~~military, intern and~~ intern/resident, and student members shall be exempt from the payment of dues and assessments.

(B) Associate members shall pay one-half of all dues and assessments.

(C) New active members of the Society entering practice in Arkansas shall be exempt from dues from the date of entry into practice until the next regular dues period. The following year, the dues assessment shall be at one-half the total amount. Thereafter, full dues are payable.

(D) *The House of Delegates upon recommendation from the Council, may assess a nominal annual fee on Life and Emeritus members to cover administrative and overhead costs associated with providing Society publications and services.*

Section 4. Delinquency

Members are considered delinquent if their dues and assessments are not received by this Society by March 1, of each year, or by such other date as may be prescribed by the House of Delegates. Delinquent members shall not be entitled to any rights or benefits of this Society, nor shall they take part in any of its proceedings until such delinquency has been resolved.

Section 4. Suspension or Expulsion

~~Any person who is under sentence of suspension or expulsion from a component society or whose name has been dropped from its roll of members, shall not be entitled to any of the rights or benefits of this Society, nor shall he be permitted to take part in any of its proceedings until he has been relieved of such disability.~~

Section 5. Suspension or Termination of Membership

- A) Any member shall have their membership suspended or terminated for failure to pay their annual dues and assessments or upon official notification from a component society that a member is not in good standing, subject to the member's right of appeal as provided in Section 6 of this Chapter.
- (B) The Executive Committee, after due notice and hearing, may suspend or terminate a person's membership in the Arkansas Medical Society for an infraction of the Constitution or these Bylaws, for a violation of the Principles of Medical Ethics, or for unethical or illegal conduct, subject to the member's right of appeal as provided in Section 6 of this Chapter.
- (C) Membership in the Arkansas Medical Society shall automatically be terminated if a member ceases to meet the requirements for membership as specified in Section 1 of this Chapter. This provision shall not apply to Life or Emeritus members who have fully retired from the practice of medicine.

Section 5. Meeting Registration

~~Each member, each member chosen as a delegate, and each guest in attendance at an annual session of the Society shall register in such manner as may be provided by the Executive Vice President, giving his name, address, and the component society of which he is a member. When his right to membership has been verified by reference to the roster of his society, he shall receive a badge which shall be evidence of his right to all privileges of membership at that session. No member shall take part in any of the proceedings of an annual session until he has complied with the provisions of this section.~~

Section 6. Appeals

- (A) Any member who may feel aggrieved by the action of this Society or of the member's component society in denying membership, or in suspension or termination, shall have the right to appeal to the Council.

(B) Notice of Appeal shall be filed with the Council within thirty (30) days of the date of the action on which the appeal is taken, and the appeal shall be perfected within ninety (90) days thereof. The decision of the Council shall be final.

- (C) The Council chairman shall have the power to appoint special committees from among the members of the Council to hear appeals; provided no member from the same councilor district as the appellant shall serve on said committee.
- (D) The Council shall establish rules and procedures to be followed in hearing appeals and shall furnish these to all parties involved in the appeal upon receipt of the Notice of Appeal.

Section 6. Continuing Medical Education

~~Continued membership in the Society is dependent upon compliance with continuing medical education requirements as specified below:~~

(A) Classification of Members Affected

~~All members of the Society will comply with this charge, except those retired from practice, those still engaged in their formal medical or specialty education, non-resident members and those in full-time administrative positions. Those members unable to fulfill requirements because of impaired health or extenuating circumstances may be exempt on a temporary basis by the Committee on Continuing Medical Education.~~

(B) Central Authority

~~The Committee on Continuing Medical Education will be charged with the determination of the requirements for maintaining membership in the Society. Their initial determination as well as any changes recommended must be submitted to the House of Delegates for approval. Alterations in the number of hours of continuing medical education required may be made at any regular meeting of the Society by the House of Delegates. The Council will serve as an arbitration committee if a decision of the Committee on Continuing Medical Education is questioned.~~

(C) Acceptable Alternate Plans

~~Alternate plans of acceptable requirements which would be considered equal or exceeding the requirements established by the Committee on Continuing Medical Education and the House of Delegates would include:~~

- (1) Compliance with the requirements for the Physician's Recognition Award of the American Medical Association;
- (2) Compliance with the continuing education requirements of the American Academy of Family Physicians;
- (3) Documentation of recertification by any specialty board provided the physician limits his practice to the definition of the specialty;

- ~~(4) The continuing medical education requirements of specialty societies other than the American Academy of Family Physicians should such become established. Such programs would be subject to review by the Committee on Continuing Medical Education prior to their acceptance.~~

~~(D) Three-year Continuum~~

~~Each member subject to continuing medical education requirements shall have three years to complete the required hours. The three-year continuum begins January 1 of the initial year.~~

~~CHAPTER II. Annual and Special Sessions of the Society (Moved to Chapter III)~~

~~CHAPTER II. Component Societies (Formerly Chapter IX)~~

Section 1. Charters for Component Societies

- (A) All component societies now in affiliation with this Society or those which may hereafter be organized in this State, which have adopted principles of organization not in conflict with this Constitution and Bylaws, shall, on application and submission of their Constitution and Bylaws, receive a charter from and become a component part of this Society.
- (B) As rapidly as can be done after the adoption of this Constitution and Bylaws, a medical society shall be organized in every county in the State in which no component society exists, and charters shall be issued thereto.
- (C) Charters shall be issued only on approval of the Council, and shall be signed by the President and Secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Section 2. Component Organization

Only one component medical society shall be chartered in any county, except in the county where the University of Arkansas College of Medicine is located. In that county there may be, in addition to the regular county medical society, one component society for interns and residents and one component society for medical students. Where more than one component society exists in any other county, friendly overtures and concessions shall be made, with the aid of the councilor for the district if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Section 3. Membership Qualifications

Each component society shall be the judge of the qualifications of its own members, but as such societies are the only portals of this Society and to the American Medical Association, chartered components of the Arkansas Medical Society, every reputable person who

possesses the qualifications for membership required by Chapter I, Section 2 I of these Bylaws, and who does not practice or claim to practice nor lend support to any exclusive system of medicine, shall be eligible for membership. No physician or surgeon who solicits patients or business for himself, or for an association or other organization of which he is a member, or by which he is employed, or in which he is interested, shall be eligible for membership in this Society, and no physician who works for, is employed by, or is interested in, any association or organization which solicits patients, members or physicians, shall be eligible for membership in this Society. Any member of the Society who shall hereafter violate any of the provisions hereof shall be expelled from the Society. Before a charter is issued to any county society, full and ample notice shall be given to every such physician in the county to become a member.

Section 4. Appeal to the Council

Any physician who may feel aggrieved by the any action of the Society of his county in refusing him membership or in censoring, suspending, or expelling him, shall have the right to appeal to the Council, and its decision shall be final except that a county component society shall at all times, be permitted to appeal or refer questions involving its membership to the House of Delegates of the Arkansas Medical Society for final determination. That the Council may be aided in rendering just decisions, it is necessary that the Bylaws of each component society provide in detail the procedure to be followed in preferring charges and trying any member accused of and tried for any kind of unprofessional conduct.

In hearing appeals the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts; but in case of every appeal, both as a Board and as individual councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Section 5. 4 Transfers

~~When a Members~~ in good standing in a component society who move to another county in this State he shall be given a written certificate of these facts by the secretary of his the component society, without cost, for transmission to the secretary of the society in the county to which he they move. Pending his their acceptance or rejection by the society in the county to which he they moves, such member shall be considered to be in good standing in the county society from which he was they were certified and in the state Arkansas Medical Society to the end of the period for which his their dues have been paid.

Section 6. 5 County Jurisdiction

A Physicians living near a county line may hold his their membership in that county society most convenient for him them to attend, on permission of the component society in whose jurisdiction he they reside.

Section 7. 6 Efforts to Increase Membership

Each component society shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Section 8. 7 Representation in the House of Delegates

(A) ~~Each regular county medical society shall be entitled to one delegate to the House of Delegates of this Society for each twenty-five members or major fraction thereof, provided that the society has complied with other provisions of these Bylaws, and provided that each component society shall be entitled to one delegate.~~

(B) The component society of interns and residents shall be entitled to one delegate to the House of Delegates.

(C) The component society of medical students shall be entitled to one delegate to the House of Delegates.

(D) At some meeting in advance of the Annual Session of this Society, each component society shall elect a delegate or delegates to represent it in the House of Delegates as provided in *Chapter IV, Section 7* of these Bylaws and the secretary of the component society shall send a list of such delegates to the Executive Vice President of this Society at least ten days before the Annual Session.

Section 9. 8 Responsibilities of secretary

The secretary of each component society shall endeavor to keep a roster of its members, and of the non-affiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state and such other information as may be deemed necessary. In keeping such roster, the secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his the annual report he shall endeavor to account for every physician who has lived in the county during the year.

Section 10. Assessment

~~The Secretary of each component society shall forward its assessment, together with its roster of officers and members, list of delegates, and list of non-affiliated physicians of the county, to the Secretary of this Society on January 1st, and not later than March 1st of each year.~~

Section 9. Annual Report

The secretary of each component society shall forward its Annual Report to the offices of this Society no later than March 1 of each year. Such report shall include but not be limited to:

A. *Names of officers and their terms*

B. *Names of delegates*

C. *Names of physicians who have been dropped from membership*

D. *Names of deceased physicians*

E. *Names of members requesting change in membership category*

F. *Any dues and assessments collected by the component society in behalf of the Arkansas Medical Society and/or American Medical Association. Such monies shall be accompanied by a listing of the name, address, and amount remitted for each member.*

Section 11. Failure to Pay Assessment

~~Any county society which fails to pay its assessment, or make the report required, on or before March 1st, shall be held as suspended, and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.~~

Section 10. Failure to Submit Annual Report

~~Any component society which fails to remit any dues and assessments collected in behalf of the Arkansas Medical Society and/or American Medical Association or who fails to submit the Annual Report, as defined in Chapter II, Section 9, on or before March 1 of each year, shall be held as suspended, and none of its members or delegates shall be permitted to participate in any of the business or proceedings of this Society or of the House of Delegates until such requirements have been met.~~

CHAPTER III. Annual And Special Sessions Of The Society

Section 1.

The Society shall hold an Annual Session of the House of Delegates at such place as has been fixed by the Council. ~~at the annual session two years in advance.~~

Section 2.

Special meetings of ~~either the Society or the House of Delegates~~ shall be called by the President on petition of the Council, twenty delegates, or fifty members.

~~CHAPTER III. General Meetings~~

~~Section 1:~~

~~All registered members may attend and participate in the proceedings and discussions of the general meetings and of the Section. The general meetings shall be presided over by the President or by one of the Vice Presidents, and before them shall be heard the address of the President and the orations, and such scientific papers and discussions as may be arranged for in the program.~~

~~Section 2:~~

~~The general meetings may recommend to the House of Delegates the appointments of committees or commissions for scientific investigations of special interest and importance to the profession and public.~~

CHAPTER IV. House Of Delegates

Section 1.

The House of Delegates shall meet on the first day of

the Annual Session. It may ~~adjourn~~ *recess* from time to time as may be necessary to complete its business; provided that its hours shall not conflict with the general meetings.

Section 2.

The order of business shall be arranged as a separate section of the Annual Session program.

Section 3.

The House of Delegates shall establish its own rules of procedure.

Section 4. Items of Business

- (A) All reports and resolutions received by the Executive Vice President sixty days prior to the annual meeting of the House of Delegates of this Society shall be printed in the Journal of the Arkansas Medical Society in the month preceding the meeting.
- (B) All reports, resolutions, and other items of business received by the Executive Vice President twenty days prior to a meeting of the House of Delegates shall be included in the meeting agenda.
- (C) Any item of business not submitted to the Executive Vice President twenty days prior to the meeting of the House of Delegates must have a two-thirds consent of attending delegates for introduction at such session.

Section 5. Reference Committees

- (A) The Speaker of the House of Delegates shall appoint an appropriate number of reference committees from the membership. ~~of the House of Delegates.~~ The Chairman shall be appointed by the Speaker. The reference committees shall serve only during the convention for which they are appointed.
- (B) All reports of committees, reports of officers, and resolutions submitted for consideration of the House of Delegates shall be referred to a reference committee, unless otherwise provided in these Bylaws, or unless otherwise ordered by a two-thirds vote of the House of Delegates.
- (C) The reference committee shall hold an open hearing at which any member of the Society may speak on proposals before the committee.
- (D) The reference committee shall recommend to the House of Delegates an appropriate course of action on each proposal referred to the committee.

Section 6. Composition

The House of Delegates shall consist of:

- (A) *Delegates elected by component societies in accordance with Section 7 of this chapter, or as provided in Section 10 of this chapter*
- (B) *The Councilors*
- (C) ~~Ex-officio, the~~ *The president, vice president, president-elect, speaker, vice speaker, secretary,*

treasurer, and past presidents of the Society; provided, however, that the ex-officio members shall have the power of voting on all subjects except the election of officers.

~~Section 6:~~ 7 Representation of Component Societies

Representation for the House of Delegates shall be based upon the number of active, *active direct*, ~~members,~~ life ~~members,~~ emeritus ~~members,~~ and associate members as of December 31 of the year preceding the annual meeting. *Medical student and intern/resident members shall not be included in the enumeration of active and active direct members for purposes of representation.*

- (A) Each regular county society shall be entitled to send to the House of Delegates each year one delegate for every twenty-five Arkansas Medical Society members, as specified in ~~(A)(1)-this~~ *section*, and one for each major fraction thereof, provided that its annual report ~~and assessment~~ are in the hands of the Executive Vice President by March 1st of each year. Each county society; ~~however, regardless of its number of members,~~ which has complied with this section, shall be entitled to *at least* one delegate.
- (B) The component society composed of ~~intern and~~ intern/resident members shall be entitled to one delegate to the House of Delegates.
- (C) The component society composed of *medical student* members shall be entitled to one delegate to the House of Delegates.

Section 7 8.

A majority of the delegates registered shall constitute a quorum.

~~Section 8:~~

~~The House of Delegates shall, through its officers, Council and otherwise, give diligent attention to and foster the scientific work and spirit of the Society and shall constantly study and strive to make each Annual Session a stepping stone to future ones of higher interest.~~

~~Section 9:~~

~~It shall consider and advise as to the material interest of the profession, and of the public in those important matters wherein it is dependent on the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse popular information in relation thereto.~~

~~Section 10:~~

~~It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse among physicians of the same locality, and shall continue these efforts until every physician in every county of the State who is reputable and eligible has been~~

brought under Medical Society influence.

Section 11:

~~It shall encourage postgraduate and research work, as well as home study, and shall endeavor to have the results utilized and intelligently discussed in the county societies.~~

Section 12:

~~It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the constitution and bylaws of that body.~~

Section 13:

~~It shall divide the State into councilor districts, specifying what counties each district shall include and, when the best interest of the Society and profession will be promoted thereby, organize in each a district medical society, and all members of component societies the Arkansas Medical Society shall be members in such district society.~~

Section 14:

~~It shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.~~

Section 15:

~~It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.~~

Section 9. The House of Delegates shall:

- (A) *elect representatives to the House of Delegates of the American Medical Association in accordance with the constitution and bylaws of that body,*
- (B) *divide the State into councilor districts, specifying what counties each district shall include and, when the best interest of the Society and profession will be promoted thereby, organize in each a district medical society, and all members of component societies the Arkansas Medical Society shall be members in such district society,*
- (C) *have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports,*
- (D) *approve all memorials and resolutions issued in the name of the Society before they shall become effective, and*
- (E) *it shall transact all business of this Society not otherwise provided for herein.*

Section 16 10.

In case of vacancy in the office of delegate, the House of Delegates shall have the authority to seat any member of that county society in attendance at said meeting as delegate, with full right to perform all the duties of that office.

CHAPTER V. Election of Officers

Section 1. Nominating Committee

The Nominating Committee shall consist of ten members of the House of Delegates, one from each councilor district. Each member of the committee shall serve for a term of two years, the terms being staggered so that odd and even numbered councilor district representatives shall be replaced on alternate years. ~~In the first year following adoption of this amendment, the odd numbered councilor district appointees shall serve for one year, the even numbered councilor district appointees shall serve for two years.~~ The names of the delegates appointed to the nominating committee shall be submitted by the senior councilors in the districts to the Executive Vice President no later than thirty days prior to the annual meeting. Following the first meeting of the House of Delegates at the Annual Session, the Nominating Committee shall meet and organize by selecting a chairman and a secretary. It shall be the duty of this committee to consult with members of the Society and to hold one or more meetings at which time the best interest of the Society and of the profession of the State for the ensuing year shall be carefully considered. The committee shall report the result of its deliberations to the headquarters office no later than February 1 in the shape of a ticket containing the names of two or more members for the office of president-elect and names of one or more members for each of the other offices to be filled at the Annual Session. ~~No two candidates for president-elect shall be named from the same county.~~

Section 2.

Nothing in this Chapter shall be construed to prevent additional nominations being made by members of the House of Delegates.

Section 3.

No member shall be eligible elected to any office of this Society who is not in attendance at the meeting at which the election is held. Exceptions may be made by the House of Delegates if the nominee is unable to be present because of circumstances beyond his control.

Section 4.

The election of officers shall be the first order of business of the House of Delegates on the last day of the Annual Session.

Section 5. Election by Ballot

All elections shall be by written ballot, except where there is only one candidate, when election may be made by acclamation, and a majority of the votes cast shall be necessary to elect.

Section 6. Terms of Office

~~Councilors shall be elected to serve a two-year term; all other terms of office are for one year. All officers shall serve until their successors are installed.~~

- (A) *Councilors shall be elected to serve a two-year term; provided no councilor shall serve more than four consecutive terms.*

- (B) *Delegates and Alternate Delegates to the American Medical Association shall be elected in accordance with the Bylaws of that organization.*
- (C) *All other terms of office shall be for one year; provided no member shall serve more than six consecutive years in the same office.*
- (D) *Members who have served in an office for the maximum number of years or terms are eligible for re-election to that same office after one year.*
- (E) *All officers shall serve until their successors are installed.*
- (F) *Provisions of this section shall apply to all current officers and fifty percent of their accumulated years in office shall count toward the specified limits.*
- (G) *One provisions of this section have been implemented, paragraphs (F) and (G) shall be deleted from these bylaws.*

Section 7.

On the expiration of ~~his the~~ term as president-elect, that person shall automatically succeed to the presidency and shall serve as president for the ensuing year.

Section 8. Vacancy in Presidency

In the event of the death or removal of the President, the President-elect shall succeed to the presidency to serve the remainder of that year and the ensuing year.

Section 9. Vacancy in Office of President-elect

In the event of the death or removal of the President-elect or ~~his the~~ inability to serve, the House of Delegates ~~shall meet within thirty days in a special session or otherwise, called by the President, to nominate and elect a president-elect, provided that such death, removal or inability to serve shall occur not less than sixty days prior to the Annual Session, in which event the election shall be at the forthcoming Annual Session.~~ Vice President shall succeed to the position until the next Annual Session at which time a special election for the office of President shall be held.

Section 10. Councilor Vacancy

In the event of the death or resignation of a district councilor, the Council shall appoint a member of the district to fill the unexpired term. The remaining councilors for the district shall confer with members in the district and make nominations for the vacancy to the Council.

Section 11. Vacancy in Office of Secretary or Treasurer

In the event of a vacancy in the office of the Secretary or of the Treasurer, the Council shall fill the vacancy until the next annual election.

CHAPTER VI. Duties of Officers

Section 1. President

The President shall preside at all meetings of the Society and shall appoint all committees not otherwise provided for. ~~He The~~ President shall deliver an annual address at such time as may be arranged, and shall perform such duties as custom and parliamentary usage

may require. He shall be the real head of the profession of the State during his term of office, and, as far as practicable, shall visit by appointment the various sections of the State and assist the councilors in building up the county societies, and in making their work more practical and useful.

Section 2. President-elect

The President-elect shall be a member of the Council and the House of Delegates. It shall be ~~his the~~ President-elect's duty to assist the President in visiting the component and district societies, and to familiarize himself become familiar with, and prepare himself for, the performance of ~~his the~~ duties when he shall have succeeded to the presidency of the Society. of the office of President. In the event of the President's temporary inability to serve, the President-elect shall serve until such time as the President is able to return.

Section 3. Vice Presidents Vice President

(A) The First Vice President shall assist the President in the discharge of ~~his the~~ President's duties. In the event of the President's temporary inability to serve, the First Vice President shall serve in his stead.

(B) The Vice Presidents may be assigned by the President of the Society as *an* ex-officio members of certain committees of the Society. The Vice President's responsibilities will be to stimulate, to guide, to maintain liaison, and to otherwise assist the assigned committees and their respective chairmen in the performance of their activities. In no instance will the Vice President usurp or supplant the committee chairman ~~chairmen~~ in his their responsibilities. The Vice President shall not have a vote in the affairs of the committees assigned to which he is assigned under provisions of this section.

Section 4. Treasurer

The Treasurer shall give bond in the sum as directed by the Council, ~~He and~~ shall demand and receive all funds due the Society, together with bequests and donations. ~~He The~~ Treasurer shall pay money out of the treasury only on a written order of the Executive Vice President; ~~he and~~ shall subject ~~his the~~ Society's accounts to such examinations as the House of Delegates may order. ~~and he The~~ Treasurer shall annually render an account of his doings and of the state of the funds in his hands: *accounting of the state of the Society's funds.*

Section 5. Secretary

The Secretary, in case of vacancy in the office of the executive vice president, shall assume the duties of that office pending the filling of the vacancy, and shall perform such other duties as are imposed by the Constitution and Bylaws. ~~He The~~ Secretary shall be the scientific and professional advisor of the Executive Vice President. ~~and shall assist the Executive Vice President concerning all matters without the jurisdiction of one not~~

~~holding the degree of Doctor of Medicine. The Secretary, as defined by the Constitution, shall be known as the Constitutional Secretary.~~

Section 6. The Speaker of the House

The Speaker of the House of Delegates shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

Section 7. The Vice Speaker

The Vice Speaker shall officiate for the Speaker in the latter's absence or ~~at his~~ by request. In case of death, resignation, or removal of the Speaker, the Vice Speaker shall officiate during the unexpired term.

Section 8. Councilors

~~Each~~ Every councilor shall be organizer, peace-maker, and censor for ~~his~~ their district. The one in each district with the longest tenure shall be considered the senior councilor. It is recommended that the councilors in each district call a meeting of the members in the district at least once each year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and for informing, improving, and increasing the knowledge and zeal of the component societies and their members.

~~The councilors shall jointly prepare and submit to the Council prior to the Annual Session a written report of their work and of the condition of the profession within their district.~~

~~The necessary traveling expenses incurred by each councilor in the line of the duties herein imposed may be allowed on submission of a properly itemized statement.~~

Section 9. Chairman of the Council

The Chairman of the Council shall (1) preside at all meetings of the Council, (2) serve as Chairman of the Executive Committee of the Council, and (3) appoint the Council committees.

CHAPTER VII. Council

Section 1. Power and Duties

- (A) The Council shall be the executive body of the House of Delegates and between Annual Sessions exercise the power conferred on the House of Delegates by the Constitution and Bylaws. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members ~~of component societies, on which an appeal is taken, from the decision of an individual councilor.~~ The Council shall elect a chairman following election of the Council members by the House of Delegates.

- (B) The Council shall be responsible for the conduct of all the business affairs of the Society. It shall employ a chief executive officer who shall be known as the Executive Vice President.

- (a) The Executive Vice President shall be responsible for implementation of policies of the Society and conducting affairs of the Society under the direction of the Council and its Executive Committee, the House of Delegates and the President. The Executive Vice President shall be the directing manager of the Society's headquarters office and the Journal office, and shall supervise the work of all salaried employees in the Society's offices. ~~He~~ The Executive Vice President shall discharge the administrative functions of the Society not within the duties of other officers or of committees to perform ~~He and~~ shall assist, at their request, all officers and committees. ~~and~~ The Executive Vice President shall keep ~~himself~~ informed in regard to nonprofessional matters affecting the medical profession, for the purpose of ~~keeping himself remaining~~ qualified to perform the services herein mentioned. The amount of ~~his~~ salary shall be fixed by the Council and ~~he~~ the Executive Vice President shall give bond as directed by the Council.

Section 2. Composition

The Council shall consist of the councilors, the president, vice president, president-elect, secretary, treasurer, immediate past president, and the Speaker of the House of Delegates. The Vice Speaker of the House of Delegates and the Delegates and Alternate Delegates to the American Medical Association shall be members ex-officio without vote.

There shall be two councilors from each district which has two hundred members or less. In districts where there are more than two hundred members, there shall be an additional councilor for each additional one hundred members. The councilors shall serve staggered terms of two years each. All councilors shall have equal voting privileges. A majority of the voting members shall constitute a quorum.

Section 3. Representation

Representation on the Council shall be based upon the enumeration of members in each councilor district in accordance with the provision for representation in the House of Delegates as defined in Chapter IV, Section 7 of these Bylaws.

Section 4. Organizing Component Societies

The Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided

for component societies until such counties shall be organized separately.

Section 3 5. Publications and Records

The Council shall provide for and superintend the publication and distribution of all proceedings, transactions and memories of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary. All money received by the Council and its agents, resulting from the discharge of the duties assigned to them, must be paid to the Treasurer of the Society. It shall annually audit the accounts of the Treasurer and Secretary and other agents of this Society and present a statement of the same in its annual report to the House of Delegates, which report shall also specify the character and cost of all the publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

Section 4 6. Meetings

The Council shall meet on the first day of the Annual Session and daily during the session and at such other times as necessary, subject to the call of the Chairman or on petition of three councilors. It shall meet on the last day of the Annual Session of the Society to organize and outline the work for the ensuing year. Between Annual Sessions, the Council shall be expected to meet at least bimonthly quarterly.

Section 5 7. Reporting

The Council shall, through its chairman, make an annual written report to the House of Delegates.

Section 6 8. Bonds

The Council shall have authority to accept or reject all bonds, *commitments and contracts*.

Section 7 9. Committees

(A) Executive Committee

The Chairman of the Council, the President, the President-elect, the Secretary, *the Treasurer*, and the Immediate Past President shall constitute the Executive Committee of the Council. The Chairman of the Council shall serve as Chairman of the Executive Committee. The Executive Committee shall have the power and authority to act for the Council between meetings of that body; all actions of the Executive Committee shall require approval or ratification of the Council. The Executive Committee shall consider matters referred to it by officers of the Society and shall report its findings or recommendations to the Council. *The Executive Committee shall have jurisdiction in all matters pertaining to (1) Active Direct membership and (2) discipline of members, subject to the member's right of appeal as provided in Chapter 1, Section 6 of these Bylaws.*

B) Budget Committee

The Budget Committee shall consist of (a) four

members appointed by the Chairman of the Council from among the councilors, and (b) the Arkansas Medical Society treasurer. The four council members shall be appointed to four-year terms, staggered so that one member is replaced each year. The terms shall begin on January 1 and end on December 31 of the appropriate years. The member with the most seniority shall serve as chairman. The Budget Committee shall present to the Council, before the first of each year, an annual budget consisting of anticipated revenue and expenses for the ensuing year as well as a report of the Society's committed and non-committed reserves. Any significant request for funds not included in the annual budget should be reviewed by the Budget Committee before they are committed. The Budget Committee shall provide for an annual independent financial audit and work to maintain the most prudent use of Society assets.

(B) (C) Council Committees

The Chairman shall, with concurrence of the Council, appoint such committees as are necessary to carry out the duties assigned to the Council by the Bylaws and House of Delegates. ~~At the discretion of the Council, the committees shall be of three types: (1) standing committees with unlimited membership tenure; (2) standing committees with staggered membership terms; and (3) ad hoc committees as may be warranted for specific purposes.~~

Section 8: 10. Appointments to Fill Vacancies

The Council shall, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates.

~~CHAPTER VIII. Committees~~

~~Section 1.~~

~~(A) The standing committees of this Society shall be as follows:~~

- ~~1. Committee on Cancer Control~~
- ~~2. Committee of Medical Legislation/Subcommittee on National Legislation~~
- ~~3. Committee on Public Health/Subcommittees on Rural Health, Maternal and Child Welfare, Tuberculosis, Heart Association, Liaison with Nursing Profession, etc.~~
- ~~4. Committee on Continuing Medical Education~~
- ~~5. Committee on Hospitals/Hospital Liaison and Arkansas Hospital Association~~
- ~~6. Committee on Public Relations/Speakers' Bureau, Liaison with Auxiliary, Liaison with Medical Assistants, Civilian Defense, etc.~~
- ~~7. Committee on Annual Session~~
- ~~8. Committee on Insurance~~
- ~~9. Committee on Medicine and Religion~~

10: Committee on Aging

11: Committee on Mental Health

- (B) Additional committees shall be considered subcommittees of the appropriate standing committee and one member of the standing committee shall be a member of the subcommittee.
- (C) Unless otherwise provided, these committees shall be appointed by the President for three-year staggered terms. The committee shall consist of not less than six members each, with each president appointing two members for a three-year period. Any vacancies through death, removal or resignation may be filled by the President at the time the vacancy occurs and for the unexpired term of the vacancy. The President and the Secretary shall be ex-officio members of all committees.

Section 2. The Duties of the Committees shall be as follows:

Committee on Cancer Control. Shall represent the Society in all activities concerned with cancer in the State. Shall directly supervise the activities of the Cancer Control Committee of the Arkansas Medical Society Auxiliary. Shall cooperate with all agencies within the State of Arkansas dedicated to the problem of cancer.

Committee on Medical Legislation. Shall represent the Society in all legislative practice. It shall keep in touch with professional and public opinion and maintain active relations with the Department of Public Affairs of the American Medical Association. It shall, at all times, endeavor to shape and guide legislation with a view to securing the best results for the whole people. It shall strive to organize professional influence so as to promote the general good of the community in local, state, and national affairs and elections. During sessions of the General Assembly, it shall keep itself informed as to the bills that are introduced, and shall inform the members of the Society through its journal or special bulletins to the end that legislation inimical to the medical profession and the public shall be defeated, and legislation fostering the interest of the public health and medical practice shall be enacted into law.

Committee on Public Health. Shall represent the Society in those affairs having for their objective the improvement in public and personal health, the prevention of epidemics, and the instruction of the people. It shall maintain close relations with the Board of Health, the State Health Officer, and the various health officials, assisting in the adoption of public health programs, the enforcement of sanitary laws, and to exercise the leadership in the health problems of school children through a subcommittee on physical fitness and school health. As occasion demands, or when thought advisable, it shall supervise the preparation of articles of timely interest for publication in the newspapers or for broadcasting over the radio for the

instruction of the public.

The Committee on Continuing Medical Education shall be responsible for consideration of all questions pertaining to medical education. It shall maintain close relations with the officials and faculty of the University of Arkansas School of Medicine, and Arkansas Academy of Family Physicians, and other groups interested in maintaining and improving medical education in our State institutions. It shall foster continuous efforts to increase excellence in the system of post-graduate education to serve the cause of medicine and to assure the public of continuing improvement in the postgraduate training of physicians in practice.

The committee shall determine continuing medical education requirements for maintaining membership in the Society, as provided in these Bylaws, and shall establish methods of reporting in compliance with the continuing medical education requirements.

The Committee on Continuing Medical Education shall consist of seven members appointed by the President as follows: The dean or a representative of the University of Arkansas College of Medicine; one representative of the Arkansas Academy of Family Physicians from three nominees by that group; one family physician member of the Society selected by the President; one surgeon selected from three nominations from the Arkansas Chapter of the American College of Surgeons; one internist selected from three nominations from the Arkansas Chapter of the American College of Physicians and two other members of the Society, not in the specialty categories listed above, selected by the President. The committee chairman shall be named by the President.

Committee on Hospitals. The Committee on Hospitals shall have referred to it all questions pertaining to hospitals and their operations; hospitalization of patients and hospital-physician relationships.

Committee on Public Relations. The Committee shall have referred to it all questions wherein the medical profession as represented by the Society is called upon for advice, for participation in private or public affairs and projects not coming within the duties outlined for the other committees. It shall be the publicity committee of the Society and shall have charge of all publicity issued in the name of the Society. The subcommittee on professional relations shall function under this committee.

Committee on Annual Session. The committee shall determine the character and scope of the scientific program for each Annual Session. It shall prepare a scientific program for each Annual Session. It shall solicit and collect material from institutions and individual physicians of the State that is of scientific interest. This it shall arrange and exhibit at each Annual Session. It should particularly strive to obtain material that will more fully illustrate the papers presented in the general meeting of the Society.

The committee shall provide suitable accommoda-

tions for meetings of the Society and the House of Delegates, the scientific exhibits, the committees, and shall have general charge of all arrangements. Its chairman shall report an outline of the arrangements to the Executive Vice President for publication in the program and shall make additional announcements during the session as occasion may require.

Committee on Insurance. The Committee on Insurance shall deal with all matters pertaining to insurance, including liaison with Blue Cross-Blue Shield.

The Committee on Medicine and Religion shall work to create and enhance communication between physician and clergyman which will lead to the most effective care and treatment of the patient in which both are interested. It shall study the areas in which there is or may be continuing correlation involving medicine and religion.

The Committee on Aging shall study the problems of the aged and the aging. It shall provide leadership and initiative in meeting the health and medical care requirements of older persons. It shall foster the development of effective methods of achieving the best possible social and spiritual atmosphere for the elderly.

The Committee on Mental Health shall study the problems of the mentally ill. It shall foster development of programs to improve the care and treatment of mental patients and mental retardates.

CHAPTER VIII. Committees

Section 1. Committees may be appointed by the president, chairman of the Council, or as may be so ordered by the House of Delegates to carry out the goals and responsibilities of this Society.

Section 2. Unless otherwise provided, all committees will be of two types: (1) Standing committees with staggered membership terms; and (2) Ad Hoc committees and Task Forces for specific purposes with limited duration.

Section 3. All committees shall have a written mission-statement that includes to whom the committee reports, the goal or purpose of the committee, and when applicable, the perceived or required time-frame for completion of the committee's work.

Section 4. All committees except those required by the Constitution and Bylaws shall be evaluated periodically, but not less than once every three years, to identify and abolish or restructure committees that are non-functional or whose purpose or mission has significantly changed or ended. It shall be the responsibility of the Executive Committee to conduct such evaluation and make recommendations to the appropriate body.

Section 5. Unless otherwise provided, standing committees shall consist of at least six members with each member appointed to a three-year term; provided no member shall serve more than two consecutive terms.

~~CHAPTER IX. Component Societies~~ (Changed to Chapter II)

CHAPTER IX. Required Attendance By Elected And Appointed Members

Any member, appointed or elected, to any position within this Society who is absent from three consecutive meetings, or who annually misses fifty percent of the meetings of the body to which they serve, shall be presumed to have resigned that position, provided, written notification has been given prior to a person missing the critical number of absences.

~~CHAPTER X. Miscellaneous~~

~~Section 1:~~

~~No address or paper before this Society, except those of the President and orators, shall occupy more than thirty minutes in its delivery and no member shall speak longer than five minutes nor more than once on any subject, except by unanimous consent.~~

~~Section 2:~~

~~All papers read before the Society or any of the sections shall become its property. Each paper shall be deposited with the Secretary when read.~~

~~CHAPTER XI X. Parliamentary Procedures~~

~~The deliberations of this Society shall be governed by parliamentary usage as contained in *Sturgis Rules of Parliamentary Procedure*, when not in conflict with this Constitution and Bylaws.~~

~~CHAPTER XII XI. Medical Ethics~~

~~The Principles of Medical Ethics promulgated by the American Medical Association shall govern the conduct of members in their relation to each other and to the public.~~

~~CHAPTER XIII XII. Amendments~~

~~The House of Delegates may amend any chapter of these Bylaws by a two-thirds vote of the delegates present at any Annual Session, provided that each amendment shall have been presented in open meeting at the previous Annual Session, and that it shall have been published twice during the year in a bulletin or journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken: meeting of the House of Delegates, provided that the amendment shall have been mailed to all members at least 90 days prior to the meeting.~~

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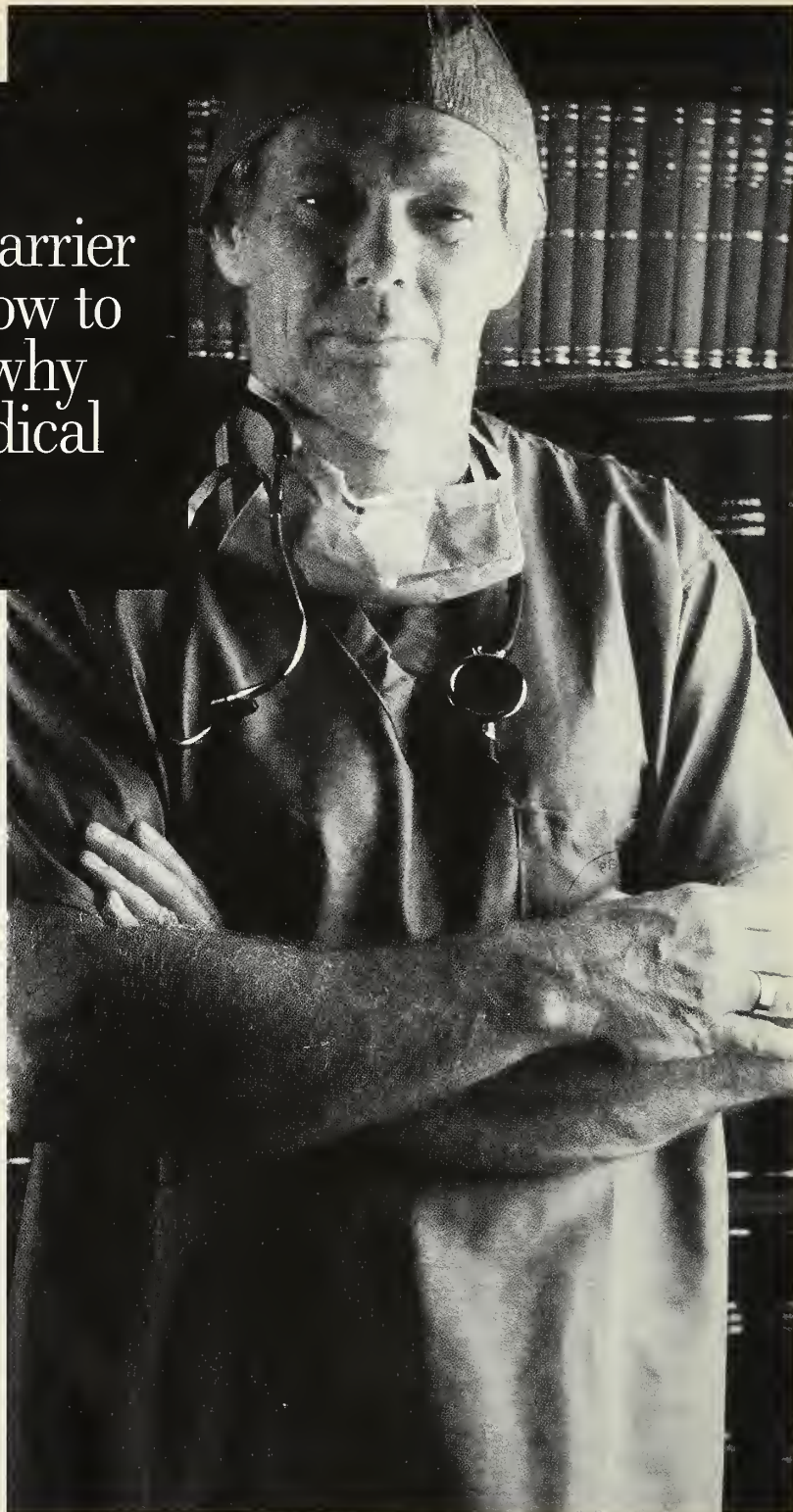
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Prenatal Care Participation In Arkansas

Susan Patton, B.S.N., R.N.P.*

"We have a choice between placing babies in the arms of their mothers, or in the arms of technology. Just \$400 in prenatal care could make the difference between a healthy baby and a baby who might need \$400,000 of help throughout life to overcome difficulties and disabilities that could have been avoided."

- National Commission to Prevent Infant Mortality

"Every pregnant woman in the United States should have access to and participate in a basic program of prenatal health care." This has become the rallying cry of children's advocates, health care planners, and policy makers in recent years. The assumption being that as soon as barriers are lifted, women will go to doctors earlier and more often and have healthier babies.

The purpose of this paper is to review what we know about prenatal care in Arkansas: the benefits, current utilization patterns, and barriers to care and discuss plans for a multi-media campaign to encourage women to seek early prenatal care.

The infant mortality rate, measured by the number of infants who die before the age of one, is an important indicator of the overall health of a community. It is a sensitive indicator of both the quality of the health care delivered and access to that health care. While strides have been made in reducing infant mortality in Arkansas, there has been a decline in the rate of progress in the 1980's. (Figure 1) In 1988, the infant mortality rate was 10.7 per 1,000 live births; 8.7 for white births and 17.5 for black births.

The factor most closely associated with infant mortality is low birthweight. Low birthweight infants account for two thirds of newborn deaths in the neonatal period. They are 40 times more likely than full term normal weight babies to die in the first month of life, and 20 times more likely to die in the first year. Much of the excess mortality among blacks is due to their lower birthweights. The incidence of low birthweight (less than 2,500 grams) is more than twice as high among black babies as among white babies.

Inadequate prenatal care is correlated with increased rates of low birthweight, premature birth, and infant mortality and morbidity.

It does appear as though the infant mortality rate in Arkansas was improving just when prenatal care services were improving in the 1970's, thanks to an array of programs designed to help poor pregnant women; Medicaid, Maternal and Child Health block grants, and the Women Infants and Children Supplemental Food Program (WIC). However, a second look (Figure 1) reveals that the drop in infant mortality was not matched by a comparable drop in the incidence of low birthweight, the goal of the prenatal care programs. The percentage of total births that were low birthweight in 1960 was 7.9 percent compared to 8.2 percent in 1987, representing an increase of 3.7 percent. The drop in infant mortality was due primarily to better medical technology able to save smaller babies.

Most information about prenatal care comes from birth certificates, which record the date of the first visit and the number of visits. The Institute of Medicine prenatal care index, developed by D. Kessner, classifies the adequacy of prenatal care by the number of visits in relation to the duration of pregnancy and the timing of the first visit. While analysis of the relationships between specific activities and specific outcomes are limited, there is widespread agreement that early and continuous comprehensive prenatal care reduces the incidence of low birthweight and is particularly beneficial to women at risk for poor pregnancy outcomes.

It is also known that prenatal care is cost effective. The Institute of Medicine Committee to Study the Prevention of Low Birthweight estimated the costs and benefits of providing prenatal care, beginning in the first trimester, to women on welfare with less than high school education, who had not been receiving prenatal care. The low birthweight rate was 11.5 percent in this group. The committee estimated that the rate would have to decline only to 10.76 percent to balance the cost of the additional prenatal care delivered against the savings in the hospitalization, rehospitalization, and ambulatory care expenses for mother and infant in the first year of life.

* Coordinator, Arkansas Healthy Futures Project, Arkansas Department of Health and University of Arkansas Medical Sciences High Risk Pregnancy Program.

1987 Arkansas Resident Data

Table 1

Percent Babies Born With Birthweight Less Than 2500 Grams By Trimester Prenatal Care Began

Trimester	Percent Low Birthweight
1	6.7
2	8.2
3	8.6
No Prenatal Care	21.4

Table 2

Percent Babies Born Preterm (EGA Less Than 37 Weeks) By Trimester Prenatal Care Began

Trimester	Percent Preterm
1	10.0
2	13.1
3	13.8
No Prenatal Care	20.2

Table 3

Percent Babies Born With APGAR Scores Less Than 6 At Five Minutes By Trimester Prenatal Care Began

Trimester	Percent APGAR <6
1	1.7
2	1.9
3	2.1
No Prenatal Care	8.0

Table 4

Mortality Rates By Trimester Prenatal Care Began

Trimester	Infant	Neonatal	Postneonatal
1	7.7	4.4	3.3
2	11.0	5.8	5.2
No Prenatal Care	19.6	13.9	5.7

According to a 1985-86 state of Missouri review of birth records, Medicaid records, and WIC records; infants born to Medicaid mothers who participated in WIC weighed 25 grams more and required an average of \$125 less in Medicaid costs in the first 45 days of life than did infants of Medicaid mothers who did not participate in WIC. The savings in the Medicaid program related to WIC participation amounted to \$.79 for every dollar spent on WIC. When all medical charges were considered instead of Medicaid alone, the benefit to cost ratio was \$1.97 to \$1.00.

Current Utilization Patterns In Arkansas

Trends in the use of prenatal care from 1969 to 1979 show steady improvement in the percentage of births to mothers who obtain prenatal care in the first trimester of pregnancy. Since 1980, this percentage has remained stable or decreased. The number of babies born to mothers who did not receive adequate prenatal care has grown by nearly ten percent since 1979. According to a ranking by The Children's Defense Fund, only five states and The District of Columbia had a lower percentage of women receiving early prenatal care in 1986 than did Arkansas. In 1987, 34.3 percent of women giving birth in Arkansas did not receive care in the first trimester; 7.9 percent received less than five visits. There has also been an increase in the percentage of births to women with late or no prenatal care. Although this trend applies to all women, the increase is more pronounced among black women. In Arkansas, in 1987, 5.4 percent of births to white mothers and 12.9 percent of births to black mothers were to women who had third trimester or no prenatal care.

Table 5

Percent of Black Babies Born to Mothers Who Had Third Trimester or No Prenatal Care

Arkansas Resident Data

1980	8.8
1985	10.3
1987	12.9

Teenage mothers are more likely to initiate prenatal care later. In Arkansas, in 1987, women aged 20 or more when giving birth were 1.5 times as likely to obtain prenatal care in the first trimester. Women less than 20 years old when giving birth were 2.18 times as likely to obtain fewer than 5 prenatal visits and 2.13 times as likely to obtain no prenatal care than women who were 20 years old or older.

The probability that a woman will obtain care late or not at all decreases steadily as her education level increases. In Arkansas, in 1987, 67 percent of mothers who had graduated

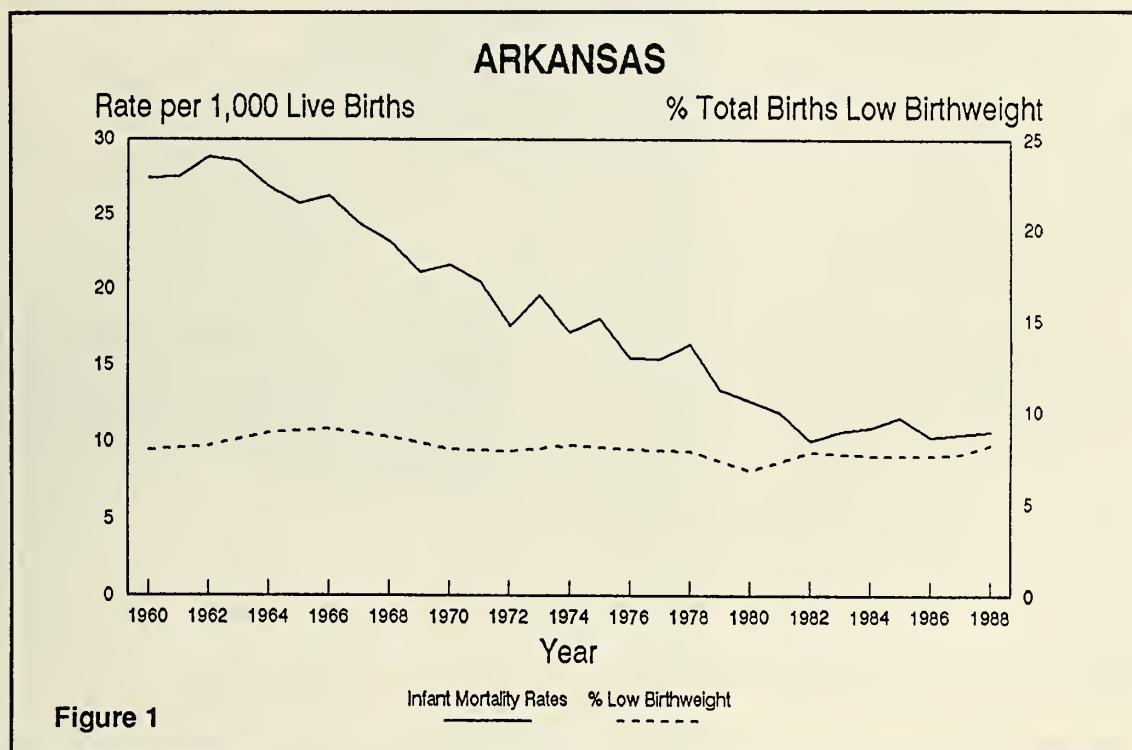
from high school received prenatal care in the first trimester, 86 percent of mothers who had graduated from college received prenatal care in the first trimester, and 51 percent of mothers who had some high school education received prenatal care in the first trimester.

Pregnant women who are married are more likely to obtain sufficient prenatal care than pregnant women who are not married. This holds true when race and education are controlled. In Arkansas, in 1987, 73.3 percent of married women initiated prenatal care in the first trimester compared to 42.5 percent of the unmarried women. In 1987, 54 percent of the births to women under the age of 20 were to unmarried women.

Medicaid eligibility correlates high with sociodemographic factors which put a pregnant women at risk. Women who are Medicaid recipients are more likely than others to enter prenatal care late, receive less adequate services, and experience poorer outcomes.

Medicaid from AFDC and requiring states to cover women and children up to 100 percent of poverty. While financial access to prenatal care has been increased through expanded Medicaid eligibility, it has not been sufficient to assure risk reduction for the poorest women with the riskiest pregnancies. Most of them are already eligible for Medicaid.

The decreased availability of perinatal services is another frequently cited barrier to care. Many areas of the country are experiencing providers who are reducing or discontinuing their obstetrical practices as well as their willingness to accept Medicaid patients as a result of an increase in malpractice premiums and risk of malpractice litigation and cost containment measures in the Medicaid program. One answer to this doctor shortage has been to raise Medicaid payments. Unfortunately, this has not been a big help for the poorest women. Higher fees alone have not been able to induce private physicians to relocate in the inner city ghettos and rural areas where poor women live. A shortage



What Are The Barriers To Receiving Care?

The General Accounting Office interviewed 1,157 women in 32 communities in 8 states to determine the barriers they perceived as preventing them from obtaining care earlier or more often. Those who obtained inadequate care most frequently cited lack of money to pay for care. Comparing a group of privately insured women with GAO's study group of Medicaid recipients and uninsured women, GAO found that the privately insured women were much more likely to begin care early in the pregnancy and see the care provider regularly. It has been estimated that one out of four pregnant women in the US is not covered by insurance (private or public). Congress responded to this need by separating

of Certified Nurse Midwives and OB/GYN Nurse Practitioners who can supplement and expand physician services compounds the health manpower shortage problem.

In inner city neighborhoods and rural areas, more women rely on community health centers and health department clinics. These clinics are relatively well distributed and well used (they provide prenatal care to over one third of the Arkansas women giving birth each year). But still, making prenatal care available does not insure utilization.

Some women must travel 2 to 3 hours to obtain prenatal care. Lack of familiarity with how and where to obtain care, inconvenient clinic hours, inability to leave work, lack of care for other children, long delays in getting appointments

and receiving services, and simply not understanding the importance of prenatal care present further barriers.

Although these barriers have been well studied and documented, their relative importance to women themselves is not well known. Few reports cite consumer views, and programs aimed at increasing participation in prenatal care are often designed without considering women's individual needs. If pregnant women in Arkansas are to receive the full benefits of what is currently known about prenatal care and health during pregnancy and in the first years of life, providers must take a radical step beyond the old expectation that the women most in need will come if the services are there. Barriers must be addressed through improved outreach.

The overall goal of the Arkansas Healthy Futures Project, supported by a four year grant from The Robert Wood Johnson Foundation awarded to the Arkansas Department of Health and the University of Arkansas Medical Sciences High Risk Pregnancy Program, is to reduce the infant mortality rate in Arkansas. One of the principal objectives of the project is to increase utilization of prenatal care services. In order to increase the percentage of Arkansas women receiving prenatal care in the first trimester, The Healthy Futures Project, with support from the Arkansas Chapter of The March of Dimes, has completed plans for a statewide media campaign to be conducted in two phases.

The first component, market research, has been subcontracted to The Miller Research Group in Little Rock, Arkansas. Goals of the research include identification of target audience, identification of sources of information for women and decision makers/influencers in the target audience, identification of potential access points, documentation of perceived barriers to seeking prenatal care, and recommendations for developing and implementing a marketing strategy. Results of the research will be incorporated into a two year long statewide media campaign to encourage women to seek early prenatal care. A statewide, toll-free hotline is planned in conjunction with the media campaign.

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Arkansas Physician In National Spotlight Regarding AIDS Epidemic

William N. Jones, M.D., newly-elected President of the Arkansas Medical Society and past chairman of the AMS Committee on AIDS, testified in Washington, D.C., on April 19, 1990, before the Subcommittee on Health and the Environment of the United States House of Representatives.

Speaking at the invitation of Congressman William E. Dannemeyer (D-CA), Dr. Jones addressed the importance of contact tracing and partner notification for the control of the spread of the AIDS epidemic. Among those who shared the panel with Dr. Jones were: Annette Strauss, Mayor of Dallas; Senator Frank Lautenberg (D-NV); Merv Silverman, M.D., President of American Foundation for AIDS Research, New York; Gabor Kelen, M.D., Director of Research, John Hopkins School of Medicine; David Wexler, Chairman of AIDS Project of Los Angeles; and Joseph Lisa, Chairman of New York City Council Committee on Health. Excerpts of Dr. Jones' remarks were featured on the CNN television news broadcast.

The following is a reprint of Dr. Jones' testimony:

I am Dr. William N. Jones of Little Rock, Arkansas, a Dermatologist in private practice. I am President-elect of the Arkansas Medical Society, Chairman of the Committee on AIDS of the Arkansas Medical Society, clinical professor of Dermatology at the University of Arkansas School of Medicine and member of the Governor's Advisory Committee on AIDS. Although I am a member of the American Medical Association, I am not here as a spokesperson for the AMA.

The principal reason I am here today is to implore you to include in any legislation on the Acquired Immunodeficiency Syndrome (AIDS), the requirement that HIV sero-positive persons be reported to the Departments of Health of the 50 states for the purposes of contact tracing and partner notification.

I am pleased to tell you that in December, 1989, this became the recommendation of the American Medical Association. It is past time for our government to take this step to help control the spread of the HIV epidemic.

For too long, we have failed to apply the same public health measures to contain the HIV epidemic as are taken to control the spread of other communicable and sexually transmissible diseases. AIDS has resulted in more than 76,000 reported deaths in this country.

Reportability and contact tracing are not new strategies in the control of sexually transmissible diseases. The purpose of reportability and contact tracing is to make it possible for the infected person to be counseled on all aspects of the infection and the determination of his or her sexual and drug

contacts so they may be interviewed, counseled and offered testing.

For more than forty years, this process has been a historically proven technique, for the control of sexually transmissible diseases and in large measure is responsible for the control of syphilis and gonorrhea.

As of July, 1989, 28 states required the reporting of persons infected with Human Immunodeficiency Virus. Colorado was the first state with such a regulation. Early experience in Colorado indicated that of the first 260 contacts interviewed, counseled and tested, 42 were sero-positive for HIV, an infection rate of 16.2%. We have been reporting and contact tracing in Arkansas since June, 1988. Our contact infection rate is 15.7%. It is apparent that those persons were previously unaware of their infection and the potential for spreading the infection to their sexual and drug contacts. Those contacts that tested negative were counseled and educated about their risk behavior and were offered repeat testing to cover the "window", the interval between infection and becoming sero-positive.

Early arguments against reportability and contact tracing were not well founded and certainly are without merit now.

The rights of an individual to privacy and confidentiality are protected in any sexually transmissible disease program. Concerns about the occasional breach of privacy and confidentiality of one individual have to be second consideration to the right of the public to be protected from this fatal viral epidemic. Concern for the previously uninformed contact has been neglected.

Some said there was no treatment, therefore there was nothing to offer the newly found sero-positive person. AZT has been unequivocally shown to lengthen the interval between the onset of infection and the development of symptomatic disease.

Volunteer testing has not been adversely affected in states where reporting is required including Colorado and Arkansas.

It is important for us to remember that HIV infection is a continuum of disease leading to death. The infected person is infectious to others from very early in his or her infection. To require reportability of the end stage of the process for statistical purposes and not require reporting of infection is incomplete policy and not in the best interest of the health and welfare of the citizens of the United States.

The longer we delay in putting this process into action, the greater the tragedy in loss of lives that could have been saved by these measures.

AIDS IN ARKANSAS 1990

January 1 - December 31, 1990

Total number of cases reported	53	CASES BY AGE GROUP	
Number of deaths	4	Less than 20	4
CASES BY SEX		20 - 29	20
Male	46	30 - 39	19
Female	7	40 - 49	9
CASES BY RACE		50 or more	1
White	42	OPPORTUNISTIC DISEASE	
Black	10	Pneumocystic Carinii	25
Other	1	Kaposi's Sarcoma	0
CASES BY RISK GROUP		Other Diseases	28
Homosexual/Bisexual	33	CASES BY RISK GROUP	
Homosexual & IV Drug User	7	Homosexual/Bisexual	33
IV Drug User	5	Homosexual & IV Drug User	7
Hemophiliac	0	IV Drug User	5
Transfusion	3	Hemophiliac	0
Heterosexual (Contacts)	2	Transfusion	3
NIR*	3	Heterosexual (Contacts)	2
# No identified risk group (NIR)		NIR*	3

AIDS IN ARKANSAS 1985 - 1990

Total number of cases reported	305	CASES BY AGE GROUP	
Number of deaths	189	Less than 20	7
CASES BY SEX		20 - 29	101
Male	277	30 - 39	134
Female	28	40 - 49	42
CASES BY RACE		50 or more	21
White	234	OPPORTUNISTIC DISEASE	
Black	68	Pneumocystic Carinii	145
Other	3	Kaposi's Sarcoma	11
CASES BY RISK GROUP		Other Diseases	149
Homosexual/Bisexual	197	CASES BY RISK GROUP	
Homosexual & IV Drug User	35	Homosexual/Bisexual	197
IV Drug User	32	Homosexual & IV Drug User	35
Hemophiliac	2	IV Drug User	32
Transfusion	15	Hemophiliac	2
Heterosexual (Contacts)	15	Transfusion	15
NIR*	9	Heterosexual (Contacts)	15
# No identified risk group (NIR)		NIR*	9

Source: Arkansas Department of Health.

Physicians With AIDS

Leo Uzych, J.D., M.P.H.

The acquired immunodeficiency syndrome (AIDS) epidemic presents increasingly ominous morbidity and mortality statistics. As of November 1989, over 186,000 AIDS cases had been reported to the World Health organization, from 152 countries. Over 107,000 of the cases are from the United States. Sadly, the figures will likely climb much higher. The Centers for Disease Control reported recently that an estimated 1 to 1 1/2 million Americans are infected with the Human Immunodeficiency Virus (HIV), that causes AIDS.

At least 353 cases of AIDS affecting physicians have been reported in the United States. In light of present estimates of 15 to 20 cases of HIV infection for every case of AIDS, it is likely that many more physicians are HIV-infected. In addition, already an estimated 2/3 OF American internists and almost 1/3 of family physicians have treated an AIDS patient.

These data raise many important, and controversial, issues. As examples: are most patients reluctant or unwilling to go to a physician who has AIDS, or is HIV-infected? How many patients would be reluctant to seek treatment from a physician if he or she treated other patients with AIDS? Are patients, by and large, informed correctly about HIV transmission? Should HIV-infected physicians and physicians with AIDS properly volunteer this information to patients? What if the patient asks for this information? And what if the patient asks the physician if he or she treats others who have AIDS, or are HIV-infected?

Some data germane to the foregoing questions have been collected. These data reveal a distinct, and disturbing, lack of public understanding regarding HIV transmission. And they also show a high level of patient concern about seeking treatment from a physician who has AIDS or is HIV-infected, or even from a physician who treats others with AIDS. In one recent, academic study, a majority of respondents indicated they would search for another physician if they learned that their physician was HIV-infected. Also, one fourth of the respondents stated that they would seek care from someone else if they learned that their physician was treating others with HIV infection. Many of the persons in the study believed that the AIDS virus may be transmitted from infected doctors to patients. Most thought that their physician should tell them if he or she was infected with the AIDS virus; and almost half felt that HIV-infected doctors should stop practicing.

Data from other surveys show that many doctors feel differently about such issues. One survey, for instance, showed that 92% of doctors believed that HIV-infected colleagues should continue to work. Survey data further showed that 44% of physicians felt that they should advise

patients if they were infected with the AIDS virus.

The best available information indicates that the AIDS virus cannot be transmitted from "casual contact" in which there is no exchange of bodily fluids. The AIDS virus may be transmitted by the sharing of needles, sexual contact and exchange of blood or bodily fluids. However, living in the same house as someone with AIDS, or working with someone who is HIV-infected, under circumstances where there is no exchange of bodily fluids does not present a risk of HIV transmission. And similarly, the risk of HIV transmission from a doctor or in the health care setting is in general very small. There are, in fact, to the author's knowledge, no documented instances in which a physician has infected a patient with the AIDS virus.

The medical profession, to its credit, has already taken steps intended to address potential problems arising from HIV-infected doctors. The Centers for Disease Control, for example, now recommends that all doctors use universal precautions. In some instances, as in the case of an HIV-infected surgeon performing invasive procedures, there may nonetheless be some risk of AIDS transmission to a patient. If any risk of AIDS transmission is raised by the professional activities of a physician, the physician in question should NOT engage in such activity.

A lot of reasons, arguably compelling, can be marshalled in support of the posture that a physician with AIDS or HIV-infected should not have to volunteer such information to patients, provided that his or her professional activities pose no risk of HIV transmission to the patient. If there is no real risk of HIV transmission, then volunteering information about HIV infection is not medically necessary to protect the patient's health, but is invasive of the physician's privacy and may severely disadvantage the physician from an economic standpoint. This is because, as noted earlier, many patients are misinformed about HIV transmission.

If a patient directly asks a physician if he or she has AIDS, or is infected with the AIDS virus, the physician obviously cannot ethically make incorrect or misleading assertions to the patient. At the same time, the physician, for reasons including the ones just given, might refuse to answer the question. If a patient asks a physician whether he or she treats others with AIDS, the physician almost certainly should decline to answer because the information requested is generally considered to be confidential.

In the not-too-distant future, almost all physicians will have treated AIDS patients. And considerable numbers of physicians themselves may be HIV-infected. The public must become better informed about how HIV is transmitted. Doctors, for their part, must avoid any professional activity possibly posing a risk of HIV transmission to their patients.



Are You Ready?

Providers' News, June 1, 1990

- * Physicians and suppliers **must file** with the Medicare carrier **all claims** for services and supplies provided to Medicare beneficiaries.
- * Claims submitted by beneficiaries for services performed on or after September 1, 1990 will be denied.
- * If you are not now an electronic biller, this may be a good time to consider making the switch ...

Arkansas Medical Society News, June 8, 1990

New Medicare Filing Requirements - This is a reminder that beginning September 1, 1990, **all** physicians and suppliers must submit claim forms for Medicare patients, whether or not assignment is being taken.

The Arkansas Express Claims system comes ready to submit electronic claims for Medicare, Medicaid, and Blue Cross/Blue Shield. A complete system, hardware, software, training, and six months of toll free support is available at this low price.

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Robert J. Miller*

Case History

"It was a classic case of first suit syndrome," recalled the seasoned defense attorney of a case in which the doctor, a 37 year old board certified otolaryngologist, was his own worst enemy.

The matter began simply enough. The plaintiff, a 62 year old widower, complained of pain in his neck and was referred to the defendant for sinogram. Test results revealed a ductal stone in the right submaxillary gland and the plaintiff was admitted to the hospital for routine surgical removal of the stone.

What Went Wrong

Surgical excision of the stone went without incident and lasted from approximately 9:30 a.m. until 11:30 a.m. Upon plaintiff's admission to the recovery room, the nurse in charge of his care noted that he was doing well. At 11:55 the nurse noted that the plaintiff's blood pressure had risen to 227/156 and he was given Antilirium at the instruction of the anesthesiologist. The nurse's recovery room notes indicate that the plaintiff was restless. Plaintiff later stated that he felt that he was choking and couldn't breathe. Because the plaintiff's arms were still restrained and he was beginning to panic, he began to bang his arms on the side of the gurney. The problem was some what complicated by the fact that, when he began to show signs of distress, the plaintiff was given further sedating medications.

Ultimately, the defendant physician returned to the recovery room at 12:20 p.m. A large hematoma had developed at the operative site. He inserted a hemovac in an attempt to drain the hematoma, but only 50 cc's of blood were removed. The defendant physician decided that the plaintiff should be returned to the operating room, but there was considerable delay in the actual transfer back to the operating room. Nearly an hour elapsed before the second surgery was commenced.

Once in the operating room, the anesthesiologist, who was never named as a defendant, attempted to intubate the plaintiff, but the hematoma burst and allowed blood into the

throat. In an effort to obtain an airway, the defendant tried, unsuccessfully, to place a needle in the plaintiff's neck. A second attempt, with a larger needle at a lower site on the neck was also unsuccessful. The plaintiff's condition was rapidly deteriorating. A tracheostomy was performed by the defendant. An airway was established. The surgical site was opened and drained of blood. The bleeding artery was located and tied, and the incision again sutured. At this point, the plaintiff began having trouble breathing; he had developed bilateral pneumothorases. Tubal thoracostomy was performed - a procedure at which the defendant was admittedly not expert. Following placement of the chest tube there was an immediate increase in oxygen levels. Blood pressure began to improve, and at approximately 4:20 p.m., the plaintiff was taken to Intensive Care Unit where he was listed in critical condition.

Plaintiff Complaints

During post-operative office visits, the plaintiff complained of headaches, left hand numbness and tingling, left chest pain, tenderness at the chest tube insertion site, random "shakes", some entrapment of the tongue and voice weakness - all attributed to the surgery. Nerve conduction studies by a neurosurgeon/neurologist revealed some medial and ulnar nerve neuropathy.

According to the plaintiff's deposition, this specialist said that the nerves had been traumatized due to the plaintiff being tightly tied down for an extended period of time. Although further follow up visits had been ordered by the defendant physician, the plaintiff instead turned to another physician for his care. It is interesting to note that, although he was not sued as a result of this surgery, the family physician was also fired by the plaintiff and his family.

In his formal complaint, the plaintiff alleged that he was forced to retire early from his career as a carpenter because of the weakness and pain in his left arm and side. He also complained of continuing fatigue, shortness of breath, and difficulty speaking and hearing.

The Legal Issues

The defendant was neither an accurate nor a sympathetic witness. But, even if he had possessed superior communica-

* Mr. Miller is the vice president of Consumer Affairs and Risk Management of the Medical Protective Company.

tion skills, he still would have been held accountable for the following issues:

- * The defendant doctor was never able to give plausible or consistent explanations for why the operative reports had been redictated twice, in more favorable terms, adding words like "meticulous" and "carefully." Handwritten additions had been made to the operative reports indicating that the previous reports had been lost - when, in fact, one set of reports were typed on the same day. Neither plaintiff's attorneys nor juries are forgiving when it comes to "fudged" records.
- * Almost an hour elapsed between the time and recovery room nurse notified the defendant of the plaintiff's deteriorating condition and the second surgery began. The doctor was unable to account for the delay other than to indicate that the surgical staff was at lunch. This pretty lame excuse did not endear him to the other defendant, the hospital. The operating room staff staunchly maintained that it was the doctor who had dawdled.
- * There was criticism of the order in which the defendant performed the emergency procedures. Expert witnesses indicated that the tracheostomy should have been performed first and the treatment of the hematoma should have been secondary; failure to establish this priority increased the danger.
- * There was also some question as to whether or not the physician should have been performing a thoracostomy. It is unlikely that he had ever before performed this procedure.

The Personality Factor

It is possible that the defendant was an individual who was unable to admit that he might ever have made a mistake. But it is also possible that, having had a relatively simple case turn into a nightmare, he thrashed around trying to extricate himself from the explosive aftermath. The reader can decide.

The physician was adamant that he had committed no error and even after serious questions had been raised about his handling of the case, he refused to consider the possibility that the patient's life had been jeopardized. When he discovered that the plaintiff's attorney, a well-respected product liability specialist, was trying his first malpractice case, the physician accused him of being on a "fishing trip" and threatened to "skunk" the attorney. Lawsuits are not cribbage games and this attorney wasn't just playing around.

The family was very angry with the defendant. Following the surgery, he allegedly admitted to several family members that he'd "really screwed up." He was defensive in his reaction to them and in a written statement said that one family member was "filled with an extremely large amount of questions, and was even at the time somewhat uncoopera-

tive." Don't families have the right to ask questions if an emergency occurs?

Because he had decided that this was not a meritorious case, the defendant did not really take it seriously. He didn't listen to counsel's concerns about the case and he behaved as though he was "above" the proceedings. Less than two weeks before the trial, the defendant's wife called the defense attorney's office to announce that she and her husband would be on vacation during the scheduled trial date and that the trial would have to be postponed. The court did not consider this a sufficient reason to postpone a trial.

In his deposition, the doctor was asked why he didn't call for help with the airway problem, in general, but with the tracheostomy and thoracotomy, in particular. His response was that he didn't want to be subject to any criticism or loss of respect from his peers.

On the first day of trial, the plaintiff's attorney deviated from standard procedure and did not call the plaintiff to the stand as his first witness. Instead, he called the defendant physician. For the entire morning, the attorney concentrated his questions on the issue of the medical records, only. With each response, the defendant made the situation worse. Not only was he unable to provide an acceptable reason for the redictation and written addenda on the operative reports, but his demeanor alienated observers. By the end of testimony, it was evident to the defendant's wife that her spouse was in serious trouble. Following a consultation with the defense attorney, the defendant physician agreed to settle and a reasonable amount was agreed upon. The gravity of the situation was so apparent to the defendant that, during settlement negotiations, he offered to write a personal check for \$10,000, if his attorney thought that might help to resolve the matter. Such a gesture was not necessary and it is to the opposition's credit that their demand was not elevated.

Altered records destroyed any possibility of extricating the doctor from this claim without a substantial payment to the plaintiff. Despite the other issues and weakness, a rigorous defense could have been made. **NEVER ALTER RECORDS.**

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Things To Come

July 21-28

8th Annual Medical Seminar. Sponsored by the North Memorial Medical Centre and the University of Minnesota Department of Family Practice. Plummer's Great Slave Lake Lodge, Northwest Territories, Canada. Twenty-one and one half CME credits available. For more information, call 1-800-665-0240.

August 3-4

Management of Non-Union and Orthopaedic Infections. Sponsored by the Washington University School of Medicine. The Ritz-Carlton Hotel, St. Louis, MO. Fifteen Category I credits available. For more information, call (314) 362-6893 or 1-800-325-9862.

August 6-10

Physicians in Management I&II. Sponsored by the American College of Physician Executives, Tampa, FL. Four Seasons Hotel, Toronto, Ontario, Canada. CME credit available. For more information, call 1 (800) 562-8088.

August 8-12

3rd Annual Meeting of the Southern Association for Oncology. Sponsored by the Southern Medical Association and the Southern Association for Oncology. Orlando, FL. Fees: \$400 SAO members; \$505 Non-members. Category I credit available. For more information, call 1 (800) 423-4992.

August 30-September 1

Keys to Successful Peripheral Intervention: Balloon, Stent, Atherectomy, and Laser. Sponsored by the Cardiovascular Institute of the South, Houma, LA. Windsor Court Hotel, New Orleans, LA. For more information, contact Jane Arnett at 1 (800) 525-8777.

September 10-14

Physician in Management I&II. Sponsored by the American College of Physician Executives, Tampa, FL. Four Seasons Hotel, Newport Beach, CA. CME credit available. For more information, call 1 (800) 562-8088.



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Keeping Up

Current Pediatric Literature Review

July 18, 12:30 p.m. Presented by AHEC-Fort Smith. Speaker: Charles Floyd, M.D. Sparks Regional Medical Center, Medical Library. One Category I credit hour. Free admission.

43rd Annual Scientific Assembly of the Arkansas Academy of Family Physician

July 19-22. Presented and sponsored by the AAFP. Excelsior Hotel and Statehouse Convention Center, Little Rock. Twenty-two CME credit hours available. For more information, call the AAFP at (501) 223-2272.

Symposium on Maternal/Fetal Infections

July 27-28, 8:30 a.m. Presented by the UAMS College of Medicine. Speakers: Frank Miller and Terry Yamauchi. Lake Hamilton Resort, Hot Springs. Seven Category I credit hours. Fees: \$95.00, physicians; \$40.00, nurses and others.

Children Having Children: Community Response to Teen Pregnancy

August 14, 8:00 a.m. - 4:00 p.m. Presented by AHEC-Fort Smith. Speakers: Charles Floyd, M.D., Mike Berumen, M.D., and Russell Williams, MSW. Westark

Community College, Breedlove Auditorium. Six Category I credit hours. Fee: \$15.00 (includes lunch).

Advances in the Management of Essential Hypertension Including Target Organ Involvement

August 24, 12:00 noon. Presented by AHEC-Fort Smith. Speaker: Edward Frohlich, M.D. Sparks Regional Medical Center, 7th floor dining room. One Category I credit hour. Free admission.

Arkansas Heartsong Retreat for HIV Plus!

September 10-13. Presented by the Arkansas AIDS Interfaith Council and Arkansas Office of RAIN (Regional AIDS Interfaith Network). 4-H Center, Little Rock. For more information, call the Christ Episcopal Church at (501) 375-5908.

Loss Prevention Seminar

October 20, 8:00 a.m.-11:00 a.m. and 12:00 noon-3:00 p.m. Presented by State Volunteer Mutual Insurance Company and co-sponsored by the Arkansas Medical Society. Fayetteville Hilton, Fayetteville. Two Category I credit hours. Free admission. For more information, call 1 (800) 633-3215 or (615) 377-1999.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

Continuing Medical Education Luncheon, third Friday, 12:30 p.m. AMI Ozark-Quapaw Room. One Category I credit per meeting.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), third Wednesday, 12:30 p.m., Conference Room, Building 1, VAMC
Mortality/Morbidity Conference, fourth Wednesday, 2:45 p.m., Conference Room, Building 1, VAMC

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Faculty Resident Seminar, third Thursday, 12:00 noon, Sturgis Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Building, Room 457
Infectious Disease Conference, second Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Building, Auditorium
Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., 2nd Floor Classroom
Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, 2nd Classroom
Pediatric Research Conference, first Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

Interdisciplinary AIDS Conference, second Friday, 12:00 noon. LaHarpe Room. Sandwich buffet is served.

Cancer Conference, third Thursday, 12:00 noon, Laboratory Conference Room. Lunch is provided.
Hematology-Oncology Conference, second Thursday, 12:00 noon, Laboratory Conference Room. Lunch is provided.
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Southwestern Bell/Arkla Room. Refreshments are provided.
Pulmonary Conference, second and fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla Room. Sandwich buffet is served.
Journal Club, every Tuesday, 12:00 noon, Conference Room 1. Lunch is provided.
GYN Surgery Cancer Conference, second Monday, 12:00 noon, AP&L Room. Lunch is provided.
Joint Tumor Conference, first Wednesday, 12:00 noon. CARTI Auditorium. Lunch is provided.

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., Conference Room 1
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lectures and case presentations. A light lunch is provided.
Pathology Conference, third Tuesday, 3:00 p.m., Pathology Library
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. A light lunch is provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC/CARTI Tumor Conference, Wednesdays, 12:00 noon, CARTI Auditorium, Markham & University
ACRC Oncology Forum, fourth Thursday, 4:00 p.m., UAMS ACRC 2nd Floor Conference Room, 1.5 credits
ATLS Provider Course, July 28-29. UAMS Education Building
Anesthesia Conference Series, Wednesdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
Anesthesia Morbidity and Mortality Conference, second and fourth Tuesdays, 6:45 a.m.; first, third and fifth Thursdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy
Child Psychiatry Clinical Case Conference, first Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Child Psychiatry Research Review, fourth Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Dermatopathology Conference, Tuesdays, 8:00 a.m., UAMS Education Building, Room G/108 A&B
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Building, Room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Building, Room G/110A&B
Emergency Medicine Grand Rounds 1, third Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Grand Rounds 2, third Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Morbidity and Mortality Conference, fourth Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Radiology Conference, fourth Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Conference, first Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Rounds, first Tuesdays 3:00 p.m., UAMS Education Building, Room B/106A&B
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology Conference Room, #M1/293.
Interdisciplinary Gynecologic Cancer Conference, Fridays, 12:30 p.m., UAMS Education Building, Room G106 A&B
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Building, Rom G/131A&B
Medicine Research Conference, three Wednesdays per month, 4:30 p.m. Shorey Building, Room 3S06
Neurology Clinical Case Conference, Thursdays, 8:00 a.m. Rotates between UAMS (7D33) and LRVAMC (3S) and ACH
Neuropathology Conference, Thursdays, 10:00 p.m. UAMS Autopsy Room
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Ob/Gyn Grand Rounds, Wednesdays, 8:00 a.m., UAMS Education Building, Room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, Room 3/150, 2 credit hours
Orthopaedic Basic Science Conference, occasional Tuesdays, 11:00 a.m., UAMS Education Bldg., Room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Building, Room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Building, Room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Building, Room B/135
Pathology Autopsy Conference, Mondays, 9:05 a.m., LRVAMC Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
St. Vincent Urology Grand Rounds, first Tuesday, 5:30 p.m., St. Vincent Infirmary, Education Building, Room 159
Surgery Basic Sciences Conference, first Wednesday, 4:00 p.m., UAMS Education Building, Room G/141
Surgery Morbidity and Mortality Conference, Wednesdays, 7:00 a.m., UAMS Education Building, Room G/141A
Surgery Staff/Clinical Case Conference, alternating Tuesdays, 7:00 a.m., UAMS Education Building, Room G/141/
Surgery Review Conference, every second, third and fourth Wednesday, 4:00 p.m., UAMS Education Building, Rom G/141
Urology Basic Sciences Conference, second Tuesday, 5:00 p.m., UAMS Education Building, Room G/106A&B

Urology Clinical Didactic Conference, third Tuesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Core Conference, once or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Grand Rounds, second and fourth Tuesday, 5:00 p.m., VAMC-LR (4D)
Urology Morbidity and Mortality Conference, last Wednesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Teaching Conference, once or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Uro-Radiology Workshop (Urologic Imaging), once monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
VA Chest Conference (combined Surgical/Medical Chest Conference), alternating Mondays, 12:15 p.m., VAMC-LR, Room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine Conference Room, Room 1D173
VA Hematopathology Conference, Wednesdays, 3:00 p.m., LRVAMC Conference Room
VA Lung Cancer Conference (combined Medical/Surgical Lung Cancer Conference), Tuesdays, 3:00 p.m., LRVA, Room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Building 68
VA Physical Medicine and Rehab Grand Rounds, fourth Friday, 11:00 a.m., VAMC-NLR Building 68, Room 118 or Arkansas Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, Room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine, Thursdays, 8:00 a.m., VAMC-NLR Building 68, Room 118
VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology Conference Room
Vascular/Radiology Conference, Thursdays, 7:00 a.m., LRVAMC Radiology Conference Room
Vascular Teaching Conference, Thursdays, 8:00 a.m., LRVAMC Radiology Conference Room.

EL DORADO - AHEC

Behavioral Sciences Conference, first and fourth Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, second Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second and fourth Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, fourth Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, first, second and third Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

Cardiology Lecture Series, first Monday, 1:00 p.m., Washington Regional Medical Center
City Hospital Staff Meetings, second Friday, 12:00 noon, Fayetteville City Hospital
Family Medicine Conference, each Tuesday and Wednesday, AHEC - NW, 241 W. Spring, Fayetteville
Internal Medicine Conference, each Tuesday, 12:00 noon, Washington Regional Medical Center

FORT SMITH - AHEC

Internal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first and third Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, June 22, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.
Chest Conference, second Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided
Cleburne County Medical Society, second Thursday, 12:00 noon, Cleburne Memorial Hospital - Herbert L. Thomas Conference Room, Heber Springs
Eaker AFB CME Conference, second and third Wednesday, 12:00 noon or 4:00 p.m., Hospital Cafeteria
Independence County Medical Society, second Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, fourth and fifth Tuesday, 12:00 noon, St. Bernards Dietary Conference Room. Lunch provided.
Jackson County Medical Society, third Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, third Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, second Tuesday, 7:30 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neurological-Neurosurgical Conference, first Monday, 12:00 noon, St. Bernard's Dietary Conference Room
Neuroradiology Conference, third Friday, 12:00 noon, St. Bernards Dietary Conference Room. Lunch provided.
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Pocahontas CME Conference, third Wednesday, 12:00 noon and 7:30 p.m., Randolph County Medical Center Boardroom
Walnut Ridge CME Conference, third and last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
West Plains CME Conference, fourth Wednesday, 6:30 p.m., West Plains Country Club, West Plains, MO

PINE BLUFF-AHEC

Behavioral Science Conference, first and third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second and fourth Friday, 12:00 noon, Jefferson Regional Medical Center

Family Practice Conference, first and fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, second and fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second and fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Cine Radiology, second Friday, 12:00 noon, Wadley Regional Medical Center.
Echo-Cardiology, fourth Friday, 12:00 noon, Wadley Regional Medical Center
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Neuro-Radiology Conference, first and third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

Medicine in the News

Health Care Access Foundation Update

As of May 1990, the Arkansas Health Care Access Foundation has provided free medical services to 1,408 medically indigent persons.

The program has 1,478 volunteer health care providers including medical doctors, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.

AMA Gets New Headquarters

The American Medical Association has moved its headquarters to a new building and will have a new address beginning August 16 and new phone number beginning August 27.

American Medical Association
515 North State Street
Chicago, IL 60610
(312) 464-5000

The AMA will be sending out their new directory as soon as it is available and it will reflect their new telephone numbers.

UAMS Physician Develops New Program

Nicholas P. Lang, M.D., associate professor of Surgery at UAMS, in conjunction with the Association for Surgical Education, recently developed a computer-based, surgical education program for junior medical students who are completing Surgery clerkships. The Arkansas Caduceus Club and the UAMS College of Medicine combined to purchase the \$15,000 of equipment needed for the project. The equipment consisted of two Macintosh Apple II computers, a laser printer, a high resolution video card, a color monitor and a telephone modem.

Dr. Lang, who is a certified project developer for the Apple Computer Company, converted textbook material, including both words and images, to the computer software to form an invaluable teaching tool for the students. "This is an excellent opportunity for the UAMS to take a leadership role in the development of new and innovative educational techniques," said Dr. Lang.

AMA's Target 2000

The American Medical Association, in conjunction with the AMA National Coalition on Adolescent Health, is implementing a new project to improve the health of our

nation's adolescents during the next decade.

This three-year project, entitled "Healthier Youth by the Year 2000," is being funded by the U.S. Public Health Service's Office of Disease Prevention and Health Promotion (ODPHP) to promote the Year 2000 Health Objectives for the Nation. The objectives, scheduled for release in September 1990, will make recommendations to reduce high-risk behaviors and prevent health problems among all the nation's age and population groups.

The ODPHP funded nine projects to work toward implementing the objectives. Each project focuses on improving the health of a specific at-risk population group or on health issues within a particular community setting. The goal of the AMA's project is to stimulate the development of programs and policies that will help achieve the adolescent health objectives by the year 2000.

New Format for Drug Evaluation Reference Book

A major change in format highlights the latest edition of Drug Evaluation. The AMA's reference book, retitled Drug Evaluations: Subscription, is a three-volume, 88-chapter loose-leaf product supplied with binders and a separate comprehensive index. Quarterly update packets complete the yearly subscription package with newly revised chapters, evaluations of recently approved drugs and treatment INDs, a new index, and the drug information bulletin DE Monitor. Written by professionals in clinical pharmacology, with input from practicing physicians, the new product is designed to provide timely information in a flexible format.

DE Subscription continues the 20-year tradition of the Drug Evaluations textbook format by providing basic information on principles of therapeutics and pathogenesis of diseases in addition to clinically oriented, unbiased, comparative discussions of drugs and drug classes and information on unlabeled uses and other emerging therapies. More than 2,000 prescription and non-prescription drugs are evaluated, including more than 75 new drugs and more than 85 new investigational agents and uses.

As in the past, the new version contains numerous tables and figures for quick access to information, structural chemical formulas for virtually all the drugs discussed, and extensive chapter referencing.

To order the new book, call (800) 621-8335.

WILK vs. AMA

As you no doubt know, the Court of Appeals for the Seventh Circuit recently affirmed the district court opinion in the WILK case. You probably also are aware that the American Chiropractic Association has extensively advertised this fact in an effort to improve the economic status of its members. Much of the information the ACA has circulated is misleading. We will respond in kind in

the near future. The purpose of this is to correct any misperception you or your members may have regarding the effect of the WILK case.

The case is not over. The AMA will seek review of this case by the United States Supreme Court.

Neither the district court opinion or the more recent appellate ruling changes the law with regard to physician-chiropractor relations. The decision whether to associate with chiropractors continues to be left to individual physicians and hospitals. The Court of Appeals stated that "neither this court nor the district court would require the AMA to endorse chiropractic, nor do we mandate that there be referrals...physicians, hospitals, and other institutions must be free to make their own uncoerced decisions on whether to professionally associate with chiropractors. We do not compel medical physicians to praise or sponsors chiropractor's work...we do not even require cooperation or friendliness." Consistent with this holding, the AMA's ethical principles have for more than a decade left it up to individual physicians to judge whether association with chiropractors is in the best interest of their patients.

Both the district court and the Court of Appeals declined to determine whether chiropractic has a scientific basis. Significantly, however, the plaintiff chiropractors in WILK admitted that chiropractic should not be used for treatment of diseases such as cancer, diabetes, heart disease, high blood pressure, and infection.

In upholding a standard of the Joint Commission of Accreditation of Health Care Organizations that a majority of the executive committee of medical staffs be physicians, the district court stated that "the evidence supports no conclusion other than that patient care in acute care hospitals, and the medical staffs of acute care hospitals, ought to be under the control of fully licensed physicians rather than limited licensed practitioners." This ruling was affirmed on appeal.

The district court found, and the Court of Appeals agreed, that the dominant motivating factor in the AMA's ethical statements on chiropractic "was patient care and the AMA's subjective belief that chiropractic was not in the best interests of patients."

The plaintiff chiropractors in WILK have not sought, let alone proved, any damages as a result of the AMA's ethical principal. Even if the recent Court of Appeals decision is permitted to stand, there will be no change in the AMA's actions with respect to the relationship between physicians and chiropractors.

If you have any questions concerning the WILK case or the AMA's position on physicians and chiropractors, contact the AMA's Office of the General Counsel.

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AMS NewsMakers

M. Joycelyn Elders, M.D., director of the Arkansas Department of Health, has been selected to receive an award in the area of Distinguished Service within the Public Service Sector in the American Medical Association National Congress on Adolescent Health Awards Program. Dr. Elders was one of 33 award winners chosen from over 140 nominations from across the U.S. as representing persons or programs contributing significantly to the improvement of adolescent health.

Raymond P. Miller, M.D., of Little Rock, has been elected to the UAMS Foundation Fund Board. Dr. Miller specializes in internal medicine and pulmonary disease and is associated with the Little Rock Internal Medicine Clinic.

Bob Hoagland, M.D., of Dumas, was recently named "Doctor of the Year" by the staff of doctors at the Delta Memorial Hospital by secret ballot.

AMI National Park Medical Center has selected nine physicians to serve on its executive committee. The committee includes **Richard Gardial, M.D.**, chief of staff; **Brenda Powell, M.D.**, vice chief of staff; **Clinton Schmidt, M.D.**, secretary; **Robert McCrary Jr., M.D.**, past chief of staff; **Richart Wyatt, M.D.**, chief of OB/GYN; **Don Slaton, M.D.**, chief of medicine; **Jon Robert, M.D.**, chief of pediatrics and **John Simpson, M.D.**, RMAC representative.

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New Members

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LOGAN COUNTY

Parker, Chuck, Family Practice, Booneville. Born October 10, 1956, Little Rock. Practice experience, two years. Board certified.

PHILLIPS COUNTY

Bell, L.J., Family Practice, Helena. Born February 2, 1954, Memphis, TN. Medical education, University of Health Sciences College of Osteopathic Medicine, Kansas City, MO, 1986. Internship, Lakeside Hospital, Kansas City, MO, 1987. Practice experience, 1 year.

SEBASTIAN COUNTY

Kalec, John M., Physical Medicine and Rehabilitation, Fort Smith. Born July 25, 1954. Medical education, Autonomous University of Guadalajara, Mexico, 1983; University of Illinois School of Medicine, Chicago, IL, 1985. Internship, West Suburban Hospital, Oak Park, IL, 1986. Residency, University of Illinois, Chicago, IL, 1989.

Rivera, Raul E., Internal Medicine/Cardiology, Fort Smith. Born October 5, 1952, Nveva San Salvador, El Salvador. Medical education, University of El Salvador, 1980. Internship/residency, Mt. Sinai Medical Center, Cleveland, OH. Board eligible.

Steinsiek II, James W., Family Practice, Fort Smith. Born February 9, 1955, Leachville. Medical education, UAMS, 1985. Internship/residency, AHEC/UAMS, Fort Smith, 1989. Board certified.

RESIDENT SECTION

Ashcraft, Melessa E. Born February 28, 1963, Little Rock. Medical education, University of Arkansas, Little Rock, 1980.

Baxter, Malcom E., General Surgery. Born March, 26, 1963, Memphis, TN. Medical education, University of Mississippi, Jackson, 1990.

Beck, James F., Internal Medicine. Born December 8, 1960, Little Rock. Medical education, UAMS, 1983.

Beck, William A., Family Practice. Born August 6, 1962, Beaver, PA. Medical education, UAMS, 1990.

Bradshaw, Stace T., Diagnostic Radiology. Born October 2, 1964. Medical education, Baylor College of Medicine, Houston, TX, 1990.

Brown, Stan J., Family Practice. Born September 8, 1963, Sikeston, MO. Medical education, UAMS, 1990.

Calderon, Vincent Jr. Born April 22, 1960, Pueblo, CO. Medical school, University of Texas Medical Branch, Galveston, TX, 1990.

Cannon, Robert D. Born July 22, 1958, Jonesboro. Medical education, UAMS, 1990.

Cobb, Mark A. Born January 25, 1958, Phoenix, AZ. Medical education, Vanderbilt Medical School, Nashville, TN, 1990.

Collins, Kenneth P., Family Practice. Born July 6, 1964. Medical education, UAMS, 1990.

Conley, Susan D., Anesthesiology. Born March 1, 1951, Fayetteville. Medical education, UAMS, 1990.

Cozart, David, General Surgery. Born October 12, 1964, Brownsville, TN. Medical education, University of Tennessee, Memphis, 1990.

Dean, David P., General Surgery. Born December 8, 1964, North Little Rock. Medical education, UAMS, 1990.

Dreher, Beverly, Radiology. Born September 5, 1963. Medical education, University of Texas Medical Branch, Galveston, 1990.

Glassman, Anthony L., Physical Medicine & Rehabilitation. Born May 5, 1949. Medical education, Oregon Medical Science University, Portland, OR, 1990.

Green, Michael E. Born June 30, 1964, Newport. Medical education, UAMS, 1990.

Jacimore, Laura L., Radiation Oncology. Born June 10, 1961, Russellville. Medical education, UAMS, 1990.

Jacobs, John B., Family Practice. Born January 12, 1956, Fort Smith. Medical education, UAMS, 1990.

Johnson, Kelli A. Born May 5, 1962, Texarkana, TX. Medical education, UAMS, 1990.

Kelley, Russell S. Born March 21, 1964, Bridgeport, TX. Medical school, University of Texas, Galveston, TX, 1990.

Knapple, Whitfield L., Internal Medicine. Born April 5, 1964, Searcy. Medical education, UAMS, 1990.

Lawrence, Larry H., Family Practice. Born July 15, 1960, Chicago, IL. Medical education, UAMS, 1990.

Lewis, Charles L., Psychiatry. Born April 5, 1962, El Dorado. Medical education, UAMS, 1990.

Maxson, Mary S., Pediatrics. Medical education, UAMS, 1990.

Maxson, Robert T., General Surgery. Born July 16, 1964, Pahokee, FL. Medical education, University of Texas Medical Branch, Galveston, 1990.

Montgomery, Frances R., OB/GYN. Born November 6, 1956, Helena. Medical education, UAMS, 1990.

Moran, Sean M., Internal Medicine. Born March 4,

1963, St. Paul, MN. Medical education, University of Texas Medical Branch, Galveston, 1990.

Parker, Ray K., Dermatology. Born December 12, 1962, Mobile, AL. Medical education, UAMS, 1990.

Reese, Valerie F., Family Medicine. Born June 2, 1964, Oklahoma City, OK. Medical school, UAMS, 1990

Rothrock III, Perry C., Neurology. Born May 3, 1962, Blytheville. Medical education, UAMS, 1990.

Schaffner, Randall L., Family Practice. Born September 27, 1963, Wichita Falls, TX. Medical education, Texas Tech University of Health Sciences Center, Lubbock, 1990.

Sequin, Rosa E., OB/GYN. Born January 3, 1955, San Antonio, TX. Medical school, University of Texas Medical Branch, Galveston, TX, 1990.

Smith, Leslie G., Psychiatry. Born March 27, 1964, Austin, TX. Medical education, UAMS, 1990.

Sowell, John K. Born June 24, 1965, Alabama. Medical education, University of Alabama, Birmingham, 1990.

Ulmer, Sue A. Born December 27, 1956, Malvern. Medical education, UAMS, 1990.

Wilson, James C., Family Practice. Born December 22, 1951, Escondido, CA. Medical education, Kirskville College of Osteopathic Medicine, MO, 1986.

Yassa, Nabil A., Radiology. Born December 30, 1958, Alexandria, Egypt. Medical education, Ain Shams, Egypt, 1981.

Young, Alexander H. Born November 26, 1963, Little Rock. Medical education, UAMS, 1990.

In Memoriam —

James Russell Morrison, M.D.

James Russell Morrison, M.D., of Little Rock, died Monday, June 18, 1990. He was 64.

Dr. Morrison was a former chief of staff at St. Vincent Infirmary Medical Center and past president of the Arkansas Chapter of the American College of Radiology.

Dr. Morrison was a member of the American Medical Association, the Arkansas Medical Society, and the Pulaski County Medical Society. He was also a member of the American Board of Radiology, the Radiological Society of North America and the Society of Nuclear Medicine.

Dr. Morrison is survived by his wife, Mrs. Mary Jeanette Powell Morrison; a son, James P. Morrison of Little Rock; two daughters, Mrs. Mary Ann Knox of Little Rock and Mrs. Jan Ferguson of Bedford, TX; two brothers, Charles Morrison of Siloam Springs and Jack Morrison of Tarpon Springs, FL; three sisters, Mrs. Vivian Hamm of Salina, KS, Mrs. Margaret Jarrett of McGehee, and Mrs. Joanne Sawyer of Decatur, AL; and six grandchildren.

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Physician's Recognition Award

The Physician's Recognition Award is awarded each month to physicians who have completed acceptable programs of continuing medical education. The recipients for the months of April and May are:

April 1990

Alul, Sumer H.	Fort Smith
Bishop, Robert G.	Fort Smith
Carter, J. Bradford	Harrison
Kahn, Masood N.	Fayetteville
Langston, Robert H.	Harrison
Parker, James M.	Little Rock
Petit, Carl A.	Morrilton
Shirley, David C.	Conway
Simons, Roger D.	Flippin
Smoot, John D.	Pocahontas

May 1990

Armstrong, James D.	Ashdown
Baxley, Paul J.	Batesville
Brackin, Jack H.	Huntsville
Collins, Ellis M.	Forrest City
David, Neylon	Brinkley
Diacon, William L.	Rogers
Doherty, James E.	Little Rock
Dykstra, Peter C.	Mountain Home
Hagler, James L.	Little Rock
Hanley, Larry L.	Fort Smith
Hayden, William F.	Little Rock
Hayes, Sidney	Little Rock
Jackson, James P.	Little Rock
Jones, Kenneth B.	Jonesboro
Kovaleski, Thomas M.	Little Rock
Leonard, Donald G.	Little Rock
Luck, Herman D.	Arkadelphia
McCrary, George A.	Jacksonville
Ngo, Lam	Little Rock
Nunnally, Robert H.	Camden
Platt, Michael R.	Gravette
Pollock, George D.	Osceola
Rector, Nancy F.	Little Rock
Reynolds, Roland C.	Newport
Roberts, Franklin D.	Magnolia
Thompson, Dola S.	Little Rock
Travis, Aubrey L.	Van Buren
Van Asche, Christopher	Fort Smith
Williams, Rhys A.	Harrison

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References

1. USP DI Update, September/October 1988, p 120
2. Br J Clin Pharmacol 1985;20:710-713
3. Data on file, Lilly Research Laboratories.
4. Scand J Gastroenterol 1987;22(suppl 136):61-70
5. Am J Gastroenterol 1989;84:769-774.

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2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

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Drug Interactions—No interactions have been observed with theophylline, chlorazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given

an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L). The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H₂-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

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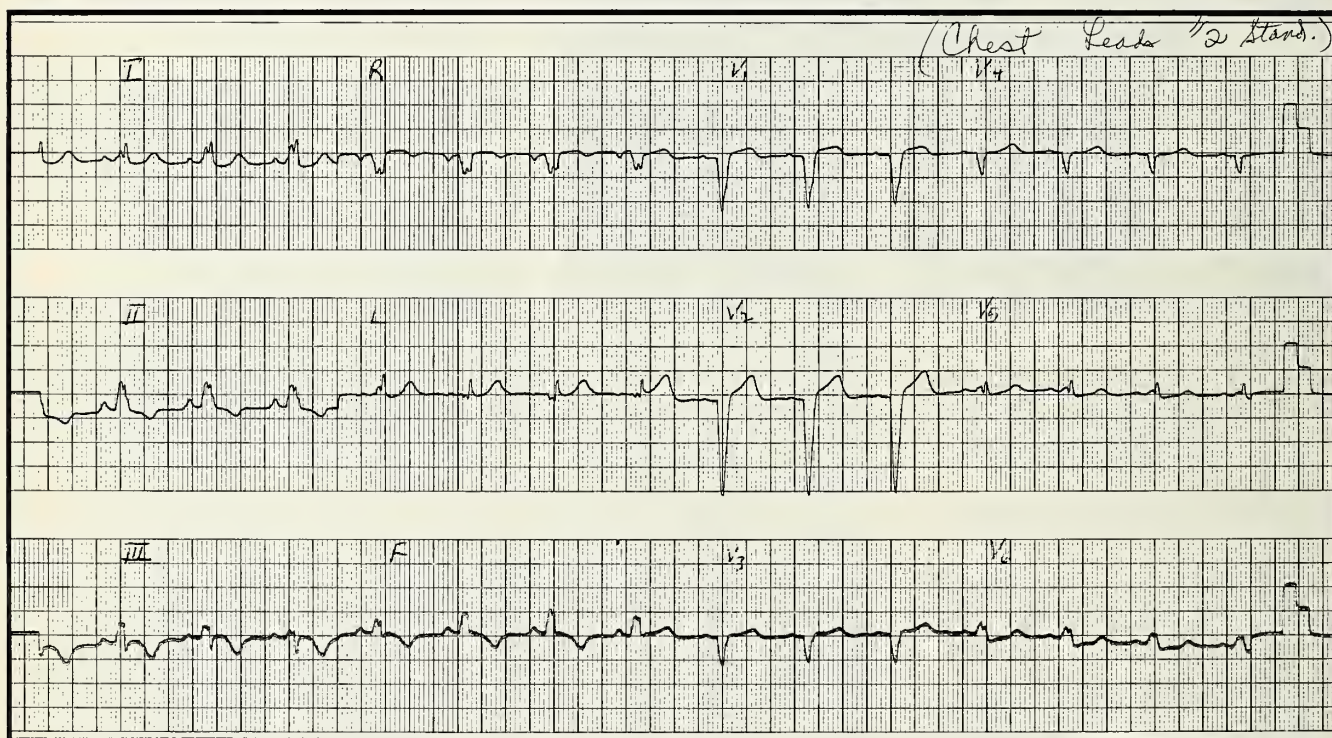
ELECTROCARDIOGRAM of the MONTH



Bart Throneberry, M.D.
John W. Watson, M.D.

CLINICAL HISTORY:

S.B. is a 57-year-old lady presenting to the hospital with complaints of crushing substernal chest pain of four hours duration associated with nausea and diaphoresis. Her physical examination showed hypotension, paradoxical splitting of the second heart sound, an S3 gallop, and crackles in the lungs. Her ECG is shown. What do think about her presentation and the electrocardiogram?



DISCUSSION:

The ECG shows sinus rhythm and changes classic for LBBB. Left bundle branch block pattern on an electrocardiogram often obscures electrocardiographic changes of acute infarction. In the face of the patient's history and physical examination, one must entertain the possibility of acute infarction, in spite of the nondiagnostic electrocardiogram.

The editor wishes to thank Dr. Throneberry of Conway for his contribution to this month's featured electrocardiogram.

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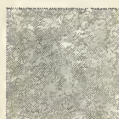
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Intractable Cholangitis Due to Conduit Obstruction

E. Stevers Golladay, M.D.*
James W. Slezak, M.D.**
Joanna J. Seibert, M.D.***

Although the anastomosis of the intestine to the bile ducts to salvage biliary atresia was performed successfully first by Ladd in 1928,¹ it was not until 1956 that Kasai performed a successful anastomosis for noncorrectable biliary atresia.² The bile drainage which occurs in the majority of patients with noncorrectable biliary atresia after operations similar to Kasai's is dependent on patent biliary ductules. Establishment of drainage does not, however, equate with cure. Many children who have achieved a jaundice-free state will develop cholangitis and varied surgical attempts to alter the incidence of this complication have not met with consistent success. Our method of handling the child through the preoperative, operative and postoperative phases has been detailed previously.³ This report deals with the subgroup of patients having cholangitis and how to manage this group.

Materials and Methods

From 1977 to 1988, 27 children were treated for the noncorrectable form of biliary atresia. There are 15 children now at least 6 months after a portoenterostomy and 13 of these are jaundice-free. Fourteen of the 15 have had at least one episode of cholangitis. Although our success initially was poor, these 15 surviving children are of the last 20 in sequence.

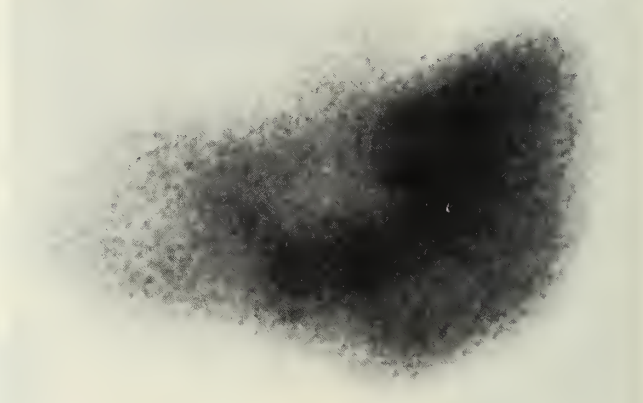
We have recognized cholangitis as presenting first with a change in the bile color or clarity, followed soon by a decreased bile output, lethargy, and then fever. The parents are instructed to bring the child to the hospital with any of these initial signs. A thorough physical examination is performed and should specifically seek an increased abdominal venous pattern or increasing ascites - each indications of hepatic related fever. Blood is drawn for bilirubin and white blood cell count with differential. If there is a leukocytosis, "left shift", or bilirubin elevation, the child is admitted and treated for "cholangitis." A blood culture and bile culture

are obtained if the child is febrile.

The child is placed on intravenous fluids, phenobarbital 2.5 mg/kg every 12 hours, Solumedrol^R (methylprednisolone sodium succinate) 30 mg intravenously every 8 hours for 3 days and a second generation cephalosporin, e.g., cefoxitin 25 mg/kg intravenously every 6 hours for 7 days or an aminoglycoside, e.g., gentamicin 2.5 mg/kg every 8 hours and continued for 7 days. If another source of fever becomes apparent, appropriate therapy is given and the cholangitis therapy discontinued.

Fourteen children have been treated for 32 episodes of "cholangitis" and that presumptive diagnosis was substantiated on 28 occasions. The other episodes leading to hospitalization were viral illnesses. In the 28 instances, two

Figure 1



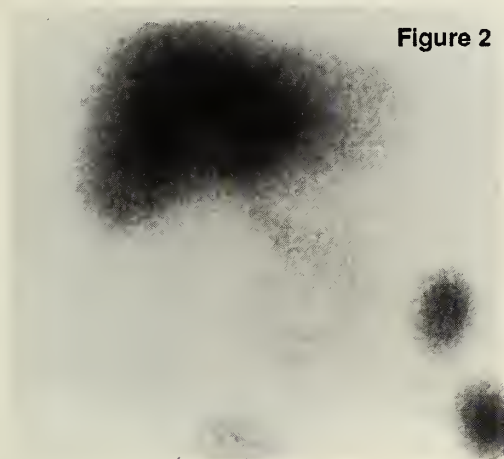
broad forms of outcome were possible: 1) a response, or 2) a failure. If the child responded to treatment as manifest by increasing bile output, decreasing bilirubin, decreasing fever, and decreasing white count, they were considered as having a successful short-term treatment and changed to the long-term treatment of postoperative biliary atresia. Our long-term treatment includes Portagen^R as our nutritional source and is administered at 180 cc/kg/day. Trimethoprim sulfa is administered at 0.5 ml/kg every 12 hours and is given for 6 months. Vitamin levels are monitored and supplemented appropriately. If there is a failure of short-term

* Dr. Golladay is a professor with the departments of surgery and pediatrics at the Arkansas Children's Hospital in Little Rock.

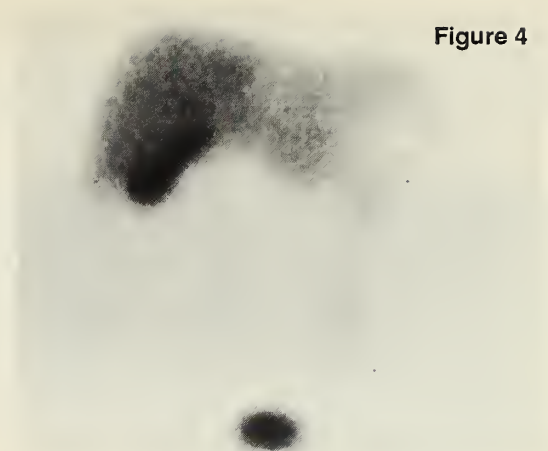
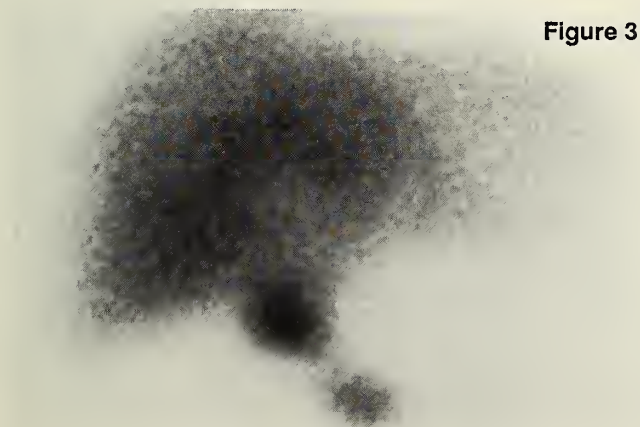
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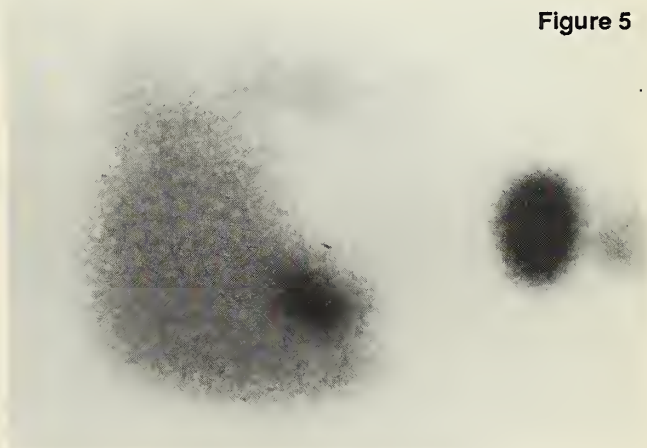
treatment as manifest by fever which persists or recurs, a repeat set of cultures and re-evaluation are performed. The enzyme inductant capability of phenobarbital must be considered in trying to achieve appropriate antibiotic levels. An increase in dosage or another choice of antibiotics as guided by culture results may sometimes convert to a short-term success.



The child is otherwise given a second pulse course of steroids and a DISIDA scan is obtained at completion of the steroid course. Our current protocol is to obtain scans at 10-minute intervals after injection for six times, at four hours after injection, and then at 24 hours. There are three distinct patterns which have been identified. The first of these we have labeled the "liver" pattern in which the imaging medium remains in the liver (figure 1). There have been nine children who have had this pattern and had curettage of the portoenterostomy performed with resolution of the cholangitis in six instances. The second variant of the radionuclide study is what we have termed the "bowel" pattern which we have defined as excretion of the bile into the bowel with no significant delay at either the liver or in the conduit (figure 2). We feel that this represents a group with gradual diminution in liver function secondary to hepatic decompensation and have generally persisted with medical management, al-



though we have unsuccessfully attempted percutaneous transhepatic cholangiography on three infants in order to try to better define the problem. Irrigation of the conduit, utilized in this group - all without notable success. The third nucleotide excretion pattern is that of most pertinence to this study and that pattern we have termed the "conduit" pattern. Prompt excretion into the conduit has generally been regarded as precluding the need for operative intervention. We have experience now with four children, each of whom had been treated for cholangitis of a recurrent and/or intractable type. The episodes had increased in frequency, severity, and intractability to treatment - a crescendo sequence. Each underwent radionuclide scanning with Tc99 DISIDA following failure of medical management. Each demonstrated prompt excretion of the radionuclide into the proximal portoenterostomy. Delayed views, however, demonstrated a distinctive pattern with rapid pooling in a subhepatic collection and subsequent slow visualization in the remainder of



the bowel (figures 3, 4, 5, 6). Each child was explored. A dilated bile-filled conduit proximal to a point of partial obstruction was found in each case - once secondary to a volvulus, twice secondary to adhesive obstruction, and once secondary to a stomal prolapse (figure 7). Each of the first three children have subsequently have been free of symptoms and is anicteric for nine months to 3 1/2 years after

operation. The last is only two weeks following operation, is without symptoms and has a resolving icterus. We have incorporated the features of our treatment plan into an algorithmic form (figure 8).

Discussion

Biliary atresia no longer has an overwhelmingly poor prognosis since the advent of Kasai's innovative approach to the problem. Long term survival may be expected in a high percentage as manifest by anicteric survival in 13 of our 27 patients. The improving survival with 15 of the last 20 patients highlights the success of careful attention to a

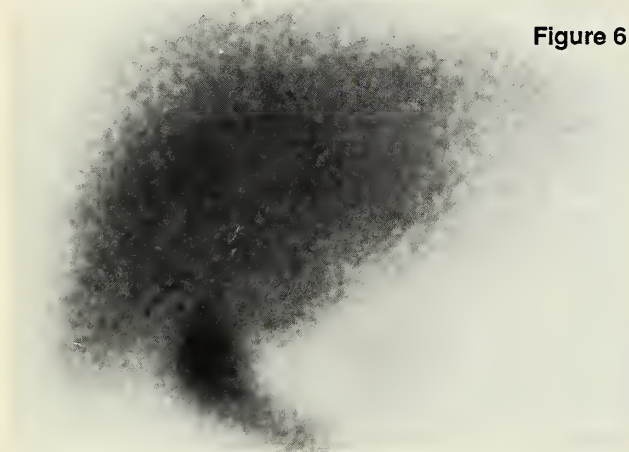


Figure 6

myriad of preoperative, operative, and post-operative details and we feel that a close effective liaison with the family is essential to obtaining good results. The hallmark of that liaison is the prompt and aggressive recognition and treatment of the cholangitis which nearly invariably has marked the course of these children.

We have shown unequivocal restitution by medical means of markedly decreased or absent bile flow in the treatment of ten episodes of cholangitis following persistent or rapidly recurrent cholangitis and a "liver" pattern. Nine children had curettage, six successfully. Three infants had a "bowel" pattern and failed to respond to irrigation and curettage. Our most successful means of conversion of a

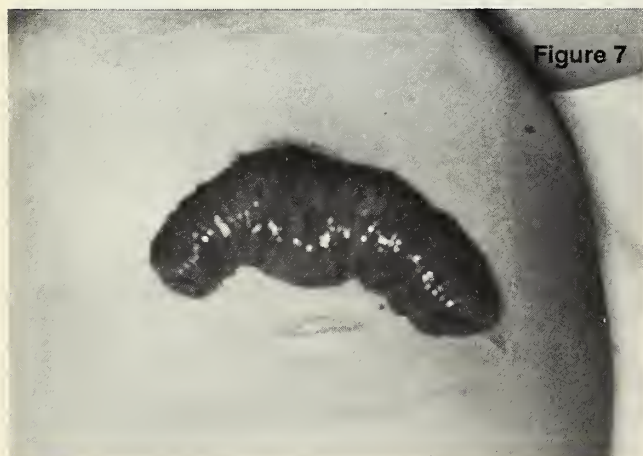
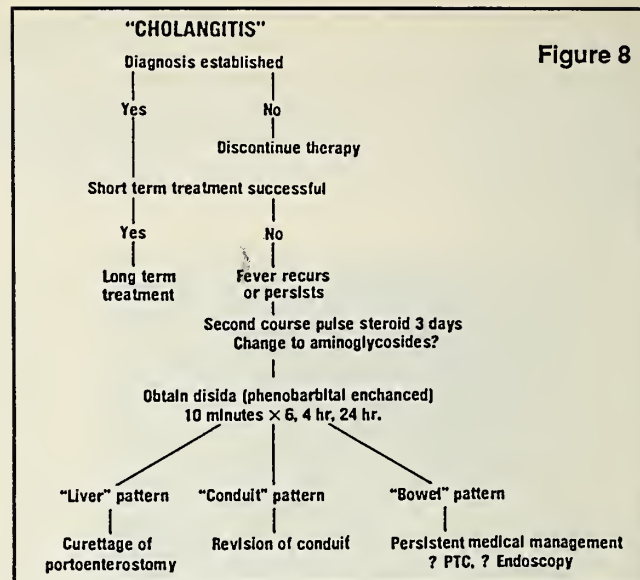


Figure 7



failed portoenterostomy is that in which a "conduit" pattern is found. Intuitively a partial obstruction of the conduit will result in recurrent and/or intractable cholangitis. Fortunately this is associated with the characteristic conduit pattern described above and illustrated by figures 3, 4, 5, and 6. Recognition of this pattern should prompt operative intervention which in each of our four cases has resulted in prompt resolution of life threatening cholangitis.

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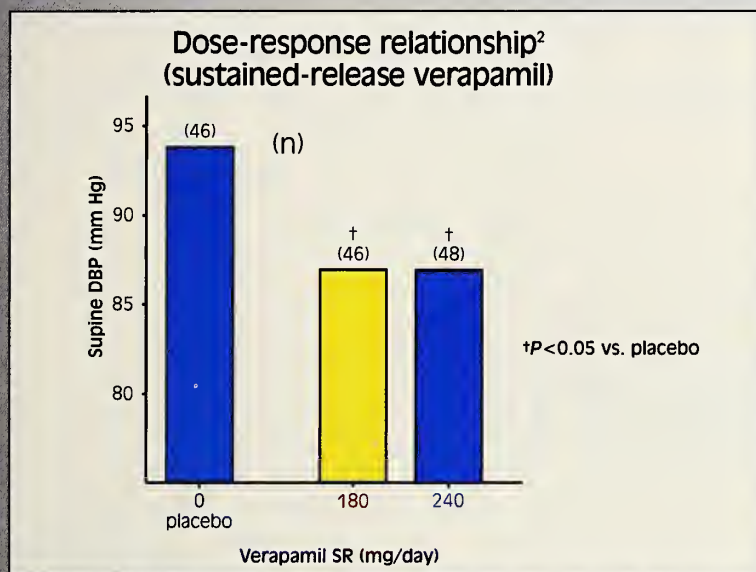


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Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

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- Data on file, G.D. Searle & Co.

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Are You Ready?

Providers' News, June 1, 1990

- * Physicians and suppliers **must file** with the Medicare carrier **all claims** for services and supplies provided to Medicare beneficiaries.
- * Claims submitted by beneficiaries for services performed on or after September 1, 1990 will be denied.
- * If you are not now an electronic biller, this may be a good time to consider making the switch ...

Arkansas Medical Society News, June 8, 1990

New Medicare Filing Requirements - This is a reminder that beginning September 1, 1990, **all** physicians and suppliers must submit claim forms for Medicare patients, whether or not assignment is being taken.

The Arkansas Express Claims system comes ready to submit electronic claims for Medicare, Medicaid, and Blue Cross/Blue Shield. A complete system, hardware, software, training, and six months of toll free support is available at this low price.

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Certified Medical Assistants Partners in Productivity

by Gina Niebes, CMA*

In the specialized field of medicine, one professional stands out - the Certified Medical Assistant (CMA).

Medical assistants are versatile professionals who perform a wide range of roles under the supervision of a licensed health care practitioner in the medical office and other health care settings. They are proficient in administrative and clinical tasks and are extensively perceived by physicians as vital partners in increasing productivity of the medical office.

Medical assisting is the nation's second fastest growing career¹⁻². Between now and the year 2000, the number of job opportunities for certified medical assistants is expected to grow by more than 90 percent.

Certification: Commitment to Professionalism

Certified Medical Assistants have earned the CMA credential and can demonstrate their knowledge and abilities with proficiency. The CMA credential is awarded to candidates who successfully complete the certification examination administered by the Certifying Board of the American Association of Medical Assistants (AAMA). The examination is a comprehensive test of the knowledge needed to perform successfully in today's medical office. The content is drawn from an in-depth analysis of the numerous clinical, administrative, and general tasks certified medical assistants perform on a daily basis. Like other professional classifications, the CMA is evidence of competence in a demanding field.

Testing for Today's Standards

Examination questions are formulated by the Certifying Board's Task Force for Test Construction. This group is comprised of practicing certified medical assistants, physicians, and medical assisting educators from across the United States. The consultant for the examination is the National Board of Medical Examiners (NBME), the same organization that develops licensure exams for physicians. Working with NBME, the Task Force updates the CMA examination annually to reflect changes in medical assistants' day-to-day responsibilities, as well as the latest developments in medical knowledge and technology.

The examination uses multiple choice questions to test knowledge in three major areas:

1. General medical knowledge - including terminology, anatomy, physiology, behavioral science, medical law and ethics.
2. Administrative knowledge - including medical records management, clerical duties, collections and insurance processing.
3. Clinical knowledge - including examination room techniques, medications, injections, pharmacology, laboratory procedures, specimen collections and surgical procedures.

To be eligible for the certification examination, applicants must meet one of the following prerequisites. An applicant must be: a medical assistant or allied practitioner who has completed at least 12 months full-time or 24 months part-time employment under the supervision of a licensed health care practitioner; a graduate of a Committee on Allied Health Education and Accreditation (CAHEA) accredited medical assisting program; or a medical instructor in post-secondary institution approved by a nationally recognized accrediting agency.

AAMA administers the examination each January and June at over 100 sites nationwide. The test is administered in Arkansas at Capital City Junior College in Little Rock and Arkansas Tech University in Russellville. To help applicants prepare for the examination, AAMA provides the Candidate's Guide to the Certification Examination. The guide explains the test format and strategies for successful completion of the exam and also includes a list of study references as well as a sample exam with answers.

Nearly 200 medical assisting programs at the post-secondary level have been accredited by CAHEA, an autonomous committee of the American Medical Association and an accrediting body sanctioned by the U.S. Department of Education.

Recertification: To Stay a Step Ahead

Being a health care professional today means maintaining a lifelong commitment to high standards of practice. CMAs are required to recertify every five years to demonstrate current knowledge. Recertification reinforces the validity of the CMA credential and helps maintain its contin-

* Ms. Niebes is the certification chairperson for the Arkansas Society of Medical Assistants, Inc.

ued acceptance by physicians, patients and other allied health professionals.

The requirement can be met in either of two ways:

- * By earning 60 recertification points through continuing education courses or academic credit. The points must be distributed equally among the three areas covered in the examination.
- * By passing the recertification exam.

Certified Medical Assistants are part of a nationwide network of health care professionals who share a common interest in advancing their careers and a common dedication to high standards of patient care. Their versatility and commitment to excellence make them valued partners in the medical profession.

For further information about certification, contact Gina Niebes at (501) 753-4593.

References

1. Bureau of Labor Statistics, A Look At Occupational Employment Trends to the Year 2000, Silvestri-Lukasiewicz, Division of Occupational Outlook, Monthly Labor Review, Sept. 1987.
2. Good Housekeeping, Twenty Top Jobs for the Year 2000, Sept. 1988.

Northeast Arkansas

Caraway (Craighead County) is located 30 miles from Jonesboro and has a population of approximately 1,165. The area the physician would serve has approximately 4,000 persons.

Caraway has an opening for a general practitioner, with clinic space available rent free. Currently, there is only one physician who is 12 miles away. The clinic has office space, a waiting room, and three examining rooms.

Sixty percent of the income is comprised of farming and 40% is industry. Caraway has two factories located within their city limits. There are five churches with most denominations represented and one school.

Recreational activities include a country club (15 miles away) with hunting and fishing closeby. There is a large recreational park with tennis courts and a baseball field. There is also a Lions Club and a Masonic Hall.

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Are We Too Easy? -- Do We Care?

Lester Hosto, P.D.*

Pharmacists, physicians, and dentists are being "ripped-off" daily by drug abusers. We all need to review our practices.

Pharmacists should screen situations, and if suspicious, the Board of Pharmacy tells them to make the suspicions known to the prescribing dentist or physician. If a pharmacy asks "do you know this person," it is a notice of suspicion. However, it is not the pharmacist who is ultimately responsible, under law, for prescribing controlled drugs.

I am an advocate of our responsibility to honest patients who are in need of medication, and we must be careful to assure that our efforts to be more responsible do not harm the honest patient in need.

Now, as you have heard the story, "It's time to quit preaching and start meddling."

When a patient you do not recognize or know calls at night or on weekends wanting pain medication, they may say "I am new in town, and I will come into the office tomorrow" or "I saw your partner yesterday" or "The last time this happened you prescribed drug X," etc. How much consideration do you give this? Are you too easy? Do you really understand the extent of the problem? Do you really understand the law?

Some facts

- * Federal law requires a practitioner/patient relationship before controlled substances are prescribed. How would you defend yourself for prescribing 24 tylenol #3 for a person you or your partners have never seen? How about three repetitions of this?
- * The abusers call the exchanges and ask who is on call and then call that practitioner and claim they saw the partner yesterday, etc.
- * Practitioners who are not partners but take on the other persons calls are especially easy prey.
- * This has been going on for years.
- * Abusers using false names and addresses get controlled substance prescriptions from dozens of dentists and doctors who have never seen and will never see the patient.

If you see the total picture, you would question -- are we too easy? Do we really care?

Case History

A pharmacist recently reported to the Board of Pharmacy a situation existed where a young female was getting controlled drugs from several practitioners. After investigating, our inspector met with the young female and her family physician.

The young female admitted that, using stories like those mentioned previously, she obtained controlled drugs from more than ten physicians and dentists; and seven of these had never seen her and did not know her. She also said she had used the line "I saw your partner yesterday" and obtained four prescriptions from two partners, and she had never seen either one.

How would this look to the public? -- Are we too easy? Do we really care?

Suggestions

1. When called (outside your office), if you do not *know* the individual, be suspicious.
2. Ask the patient if you can call them right back to verify a telephone number.
3. If they say they saw a partner, ask them to describe the partner, the office, etc.
4. If you decide to prescribe the drug --
 - a. Prescribe only enough to last until your are in the office.
 - b. Write down the patient's name and verified phone number and have the patient verified when you get to the office. If you have been lied to, report it to the state police at (501) 224-3393.
 - c. When you call the prescription, tell the pharmacist your concern and ask the pharmacist to get photo identification of the patient (drivers license) or other identification.
5. When you prescribe an antibiotic and a pain pill, ask the pharmacist to notify you if the patient only fills the pain medication.

I asked questions previously, and I hope the situation really is that we don't understand the problem.

This is my reason for this article -- to educate.

If each of us realizes the extent of the problem, I believe we would correct it.

Take my word, the problem is huge. I would guess that as many as 100 illegal prescriptions are created and filled each weekend in the Little Rock area alone.

I think we do care. We are too easy, but with awareness, we can and will address the problem.

* Mr. Hosto is the executive director of the Arkansas State Board of Pharmacy in Little Rock.

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duodenal ulcer is 300 mg once nightly
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References

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Indications and Usage: 1. *Active duodenal ulcer*—for up to eight weeks of treatment. Most patients heal within four weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than one year are not known.

Contraindication: Known hypersensitivity to the drug. Use with caution in patients with hypersensitivity to other H₂-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given Axid[®] (nizatidine, Lilly)

an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, prenatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematology—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H₂-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

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Additional information available to the profession on request.



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Axid[®] (nizatidine, Lilly)

Axid[®] (nizatidine, Lilly)

Mycopic Vision

J. Kelley Avery, M.D.*

Case #1

A 55-year-old female is admitted to the hospital because of an acute bout of abdominal pain which required surgery. Her age and medical history of mild hypertension made a pre-op chest x-ray and potassium necessary as far as the consulting cardiologist was concerned. The EKG was normal and surgery proceeded uneventfully. Recovery was prompt. The radiologist reported what appeared to be a small nodule in the right apex of the lung and suggested further study. No further mention of this lesion appears in the patient's medical record until ten months later when she reported to her internist with some left upper chest pain and a troublesome nonproductive cough. Chest x-ray done at this time revealed a 10 cm. mass right upper lung which seemed to involve the pleura. A review of the pre-op films showed the 1-2 cm. nodule and the radiologists' report which had been placed in the patient's chart two hours prior to the surgery.

Case #2

Following a one-car accident, the 34-year-old male was brought to the emergency room unconscious. He had not been wearing a seat belt. X-ray examination in the emergency room revealed no obvious skull fracture. The CT scan of the head was normal. Physical examination showed some slight ecchymosis over mid-sternal area. Chest x-ray was seen by the emergency room physician the attending neurosurgeon at 2:00 a.m. No notation of what they saw on the x-ray appeared in the medical record. The radiologist saw the film at 8:00 a.m. the next day and reported a suspicious widening of the superior mediastinum. The patient remained unconscious, but showed definite signs of neurological improvement when he went into shock, arrested and died. Autopsy showed a traumatized aorta which had suddenly ruptured.

Comments

The details are fictionalized, but similar situations occur with alarming frequency and involve all the physicians of record and their hospitals in litigation. It appears that we frequently become lost in the forest while looking for a single

tree. Do surgeons only concern themselves with the systems involved in the presenting complaint? Do cardiologists only look at the EKG? Do emergency room physicians, faced with an unconscious patient, consider only the cranial contents in their differential diagnosis? Do neurosurgeons so focus on the neurological deficit that possibility of multiple trauma is overlooked? The answer to all of these questions should be NO! Yet that is precisely what happens many times. What can we do?

Radiologists, develop a system to follow up on abnormal readings when your advice for additional studies is ignored. Call the attending physician about any determination that suggests serious problems, even if your findings are subtle and inconclusive. Specialists, ask that x-rays or other reports not be filed in the chart until you have read them. It is a good idea to initial the report indicating that you have read them. Record the positive findings in the progress note you make. The clinically significant findings on all tests need to include what action is to be taken. Emergency room physicians, call the on-call radiologist for an opinion on the report when you need it.

Most importantly, attending physicians, you are morally, ethically, and legally bound to consider the whole patient and not just a single symptoms complex. Somebody on this team must be the quarterback and call the signals. That responsibility is yours unless you formally turn that patient over to another physician.

This system failure is primary cause of lawsuits. We could eliminate this failure to coordinate and communicate by paying close attention to all our colleagues involved in the care of the patient.

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* Dr. Avery serves on the board of directors of State Volunteer Mutual Insurance Company and is Medical Director of Ambulatory Services at St. Thomas Hospital in Nashville, TN.

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AIDS IN ARKANSAS 1990

January 1 - December 31, 1990

Total number of cases reported		62	CASES BY AGE GROUP	
Number of deaths		16	Less than 20	4
			20 - 29	20
			30 - 39	24
			40 - 49	11
			50 or more	3
CASES BY SEX				
Male		53		
Female		9		
CASES BY RACE				
White		46	OPPORTUNISTIC DISEASE	
Black		15	Pneumocystic Carinii	26
Other		1	Kaposi's Sarcoma	0
			Other Diseases	36
CASES BY RISK GROUP				
Homosexual/Bisexual		35		
Homosexual & IV Drug User		8		
IV Drug User		8		
Hemophiliac		1		
Transfusion		4		
Heterosexual (Contacts)		3		
NIR#		3		
# No identified risk group (NIR)				

AIDS IN ARKANSAS 1985 - 1990

Total number of cases reported		315	CASES BY AGE GROUP	
Number of deaths		205	Less than 20	7
			20 - 29	102
			30 - 39	139
			40 - 49	44
			50 or more	23
CASES BY SEX				
Male		285	OPPORTUNISTIC DISEASE	
Female		30	Pneumocystic Carinii	147
			Kaposi's Sarcoma	11
			Other Diseases	157
CASES BY RACE				
White		239		
Black		73		
Other		3		
CASES BY RISK GROUP				
Homosexual/Bisexual		199		
Homosexual & IV Drug User		36		
IV Drug User		36		
Hemophiliac		3		
Transfusion		16		
Heterosexual (Contacts)		16		
NIR#		9		
# No identified risk group (NIR)				

Source: Arkansas Department of Health.

AIDS in Arkansas

AMS Committee on AIDS

Joseph M. Beck, M.D., Chairman

The Dollars and Sense of HIV Reporting

Jimmy D. Acklin, M.D.*

AIDS has been with us now for 10 years or more. More than 140,000 total cases of AIDS have been reported to the CDC through our state health departments. We are accustomed to reporting certain infectious diseases to our respective health policy for so long. The reasons have been obvious to most of us. Only if we know the extent of a disease and the mechanisms of its transmission can we hope to control it. Essentially no one argues with reporting cases of AIDS, yet many physicians are reluctant to report HIV infected persons who do not have AIDS. The reasons for this are numerous.

We have been very concerned about maintaining the confidentiality of our patients, since the HIV positive person may face discrimination in employment, housing and insurability. We are concerned that the patient may resent us for "turning them in" to the health department, or that they may be offended by a call from someone asking for the names of their "contacts."

Most of the arguments against reporting are invalid. Confidentiality is mandated by our state health department. No one can obtain information about who is HIV positive from the health department, although you could obtain demographic data, such as that published in the *Journal* every month on people with AIDS. And this information could certainly be valuable. I know of no case where confidentiality has been breached by health department personnel. I only wish we could say this about health care personnel in our clinics and hospitals, yet we all know this is not the case.

As for the concern that our patients will resent our "turning them in", this problem could be avoided by simply talking with our patients. We should tell our patients to expect a call from the health department, and explain to them the necessity of informing persons who might be HIV infected. If they chose, the health department will contact these persons for them, and will not use their name in doing

so. If they are still reluctant, remind them that they might not be in this situation if someone had done this in the past.

We must remember the overwhelming arguments for reporting our HIV positives and for contact tracing. Ten years into this epidemic and six years after the causative organism was identified, we still have only the most vague idea of the prevalence of HIV. Only by reporting our cases and tracing these back to the source can we possibly hope to arrive at prevalence data. Contact tracing will help us to identify persons who should be tested. More than this, it will identify those persons engaging in high risk behaviors who, through the pre- and post-test counseling, will receive the AIDS education that they obviously need. If they are not already positive, counseling may keep them from the behaviors that might lead to HIV infection in the future. If we have learned anything from this epidemic, it is that education works. The decreasing prevalence among homosexual men in San Francisco shows that when people are informed and believe that they are at risk, their behavior can change.

Denial is a major obstacle to education about HIV. Since the number of AIDS cases (140,000) is so small compared to the number of HIV positive persons (1 to 1.5 million or more), we add fuel to the fire of denial. If Arkansas could reliably report the number of HIV positive persons, this would have a major impact on the average citizen. Certainly I would be more alarmed to hear that 2000 Arkansans were HIV infected currently than to hear that only 300 Arkansans had ever been diagnosed with AIDS.

Perhaps the most compelling argument for reporting HIV positive patients is that we need the money. In this issue of the *Journal*, you will find the new application form for the Health Department's AZT Reimbursement Program. This is an outstanding program for providing Zidovudine to every person in our state who needs it. Even a person who is not yet eligible for Medicaid, and who has no insurance, can apply through this program, and be approved for this very expensive and life-saving drug. Unfortunately, the federal dollars for this program are apportioned based on the number of persons who are HIV positive. Arkansas currently has \$70,000 for AZT for this year, but we would need \$118,000

* Dr. Acklin is the assistant director of Family Practice Residency at the Area Health Education Center in Fort Smith, Arkansas and assistant director of Family and Community Medicine at the University of Arkansas for Medical Sciences in Little Rock.

just to cover the people who have already applied. By reporting our HIV positive persons, we would be assuring that those persons will have the dollars available for AZT when needed.

There are also things we can all do besides reporting HIV positive persons. Part of the problem with AIDS since 1981 has been the attitude that this was something of a special disease. As physicians, we have perpetuated this attitude by responding to AIDS in a fashion different than any disease we have encountered before. I know of no physician who would refuse to care for a patient infected with Hepatitis B virus (which is some 30 times more infectious than HIV). And we need not worry unless we make a practice of having sex, or sharing needles with our patients. Yet many of us have refused to even see and HIV infected person for an unrelated problem. Only if we can respond in a rational fashion to this disease, can we hope for the rest of our society to respond in a compassionate manner. If physicians can learn to treat HIV as a virus instead of some type of magical curse, we will be setting an example for the rest of our state. Then maybe we won't have to worry so much about our patients losing their jobs, insurance, family, and home if their infection is found out.

Arkansas Department of Health Drug Reimbursement Program

The Arkansas Department of Health (ADH) is currently administering a federally funded program to provide zidovudine (*Retrovir*) to persons who are infected with the human immunodeficiency virus (HIV) and who meet certain eligibility guidelines. The primary purpose of the program is to insure access to the beneficial effects of zidovudine therapy by HIV infected persons who lack sufficient financial resources to purchase the drug when medically indicated for the treatment of HIV infection or disease.

Zidovudine Reimbursement Program Eligibility Criteria

1. Applicant must have a medical diagnosis of HIV infection (symptomatic or asymptomatic) and be reported to the Arkansas Department of Health AIDS/HIV Registry.
2. Applicant must have a CD4 cell count less than 500/mm3.
3. Sponsoring physician must be willing to monitor and follow the medical status of the applicant during zidovudine therapy. The submission of quarterly reports on the medical status of the applicant is required by the sponsoring physician.
4. Applicant must apply for Medicaid and Social Security Disability benefits prior to application to the ADH Zidovudine Reimbursement Program. *(A ruling or determination on the applications submitted for Medicaid and Social Security Disability benefits is not required to receive benefits under the Zidovudine Reimbursement Program. An individual must simply have made application for the benefits under both of these programs.)*

bursement Program. An individual must simply have made application for the benefits under both of these programs.) The applicant must agree to allow the ADH to share medical information with the Medicaid and Social Security Disability Programs in order to facilitate the processing of applications for benefits under these programs.

5. The applicant must meet the following maximum income guidelines:

Family size:	One infected adult	Two infected adults
One	\$12,580	
Two	14,720	\$21,020
Three	16,860	23,160
Four	19,000	25,300
Five	21,140	27,740
Six	23,280	29,580
<i>For family sizes of greater than six, add \$2,140 for each additional family member and \$6,300 (the amount that would be necessary to purchase AZT and pentamidine) for each infected adult in the family.</i>		

Zidovudine (AZT) Applications

The following applications are samples of what the Arkansas Department of Health is requiring that the physicians and patients complete in order to insure access to the Zidovudine (AZT) Reimbursement Program. This program is for those HIV infected persons for whom treatment is medically indicated and who lack financial resources.

To receive copies of the applications, contact the Arkansas Department of Health at 4815 W. Markham, Slot 33, Little Rock, Arkansas 72205 or call (501) 661-2182. For more information or questions about the forms, call Bruce Thomasson, Program Analyst - Surveillance/Sero-Prevalence Coordinator, Arkansas Department of Health at (501) 661-2889. After the forms are completed, they should be returned to the Arkansas Department of Health at the above address.

ZIDOVUDINE (AZT) APPLICATION: PAGE 2 FOR COMPLETION BY PHYSICIAN
 Arkansas Department of Health; 4815 W. Markham, Slot 33; Little Rock, AR 72205

NAME OF PHYSICIAN: _____

STREET: _____

CITY, STATE, ZIP: _____ TELEPHONE: _____

NAME OF PATIENT: _____

DATE OF BIRTH: _____

PLEASE ATTACH COPIES OF
THE FOLLOWING TESTS

DATE OF ELISA: _____

T4-CELL COUNT: _____

/MM³

DATE OF WESTERN BLOT/IFA: _____

DATE OF TEST: _____

INDICATOR DISEASES

	Definitive/Presumptive	Date		Definitive/Presumptive	Date
CANDIDIASIS, Bronchi Trachea or lungs	<input type="radio"/>		ISOPORIASIS, chronic intestinal >1 month duration	<input type="radio"/>	
CANDIADIASIS, Esophageal	<input type="radio"/>		KAPOSIS SARCOMA	<input type="radio"/>	
COCCIDIOIDOMYCOSIS, Disseminated	<input type="radio"/>		LYMPHOMA, immunoblastic, Burkitt's or equivalent	<input type="radio"/>	
CRYPTOCOCCOSIS, Extrapulmonary	<input type="radio"/>		LYMPHOMA, primary in brain	<input type="radio"/>	
CRYPTOSPORIDIOSIS/ Chronic Intestinal	<input type="radio"/>		MYCOBACTERIUM AVIUM, M. Kansasi disseminated or extrapul.	<input type="radio"/>	
CYTOMEGALOVIRUS, Other than liver/spleen/nodes	<input type="radio"/>		MYCOBACTERIUM TUBERCULOSIS,	<input type="radio"/>	
CYTOMEGALOVIRUS retinitis with vision loss	<input type="radio"/>		MYCOBACTERIUM, other or unidentified species, extrapul.	<input type="radio"/>	
HIV ENCEPHALOPATHY	<input type="radio"/>		PNEUMOCYSTIS Carinii pneu.	<input type="radio"/>	
HERPES SIMPLEX: chronic ulcer(s) > 1 month duration	<input type="radio"/>		Progressive multifocal leukoencephalopathy	<input type="radio"/>	
HISTOPLASMOSIS, disseminated or extrapulmonary	<input type="radio"/>		SALMONELLA septicemia	<input type="radio"/>	
			TOXOPLASMOSIS of brain	<input type="radio"/>	
			WASTING SYNDROME	<input type="radio"/>	

TB SCREENING

PREVIOUS PPD DATE: _____

RESULT: _____

MM WHERE: _____

PREVIOUS PROPHYLACTIC INH THERAPY? YES / NO

PREVIOUS TB THERAPY? YES / NO

IF PREVIOUS INH THERAPY, DURATION IN MONTHS: _____

IF YES, LOCATION OF Rx: _____

CHECK ALL DRUGS USED IN Rx: ☐ INH ☐ RIFAMPIN ☐ ETHAMBUTOL ☐ PZA
☐ STREPTOMYCIN ☐ OTHER: _____

ANTICIPATED DOSAGE WHILE ON HEALTH DEPARTMENT PROGRAM: _____

ANTICIPATED TIME PATIENT WILL REMAIN ON HEALTH DEPARTMENT PROGRAM: _____

I certify that this patient meets official criteria for AIDS diagnosis in accordance with MMWR vol. 36, no. 15. I agree to monitor and report this patient's CD-4 count quarterly (quarterly monitoring is not necessary once levels dip below 200/cu.mm.). In the event of a significant change in clinical status, even prior to approval by this program, I agree to notify the Department of Health immediately.

SIGNATURE OF PHYSICIAN AND DATE: _____

ZIDOVUDINE (AZT) APPLICATION: PAGE 1 FOR COMPLETION BY PATIENT
Arkansas Department of Health; 4815 W. Markham, Slot 33; Little Rock, AR 72205

NAME: _____ DATE OF BIRTH: _____
STREET: _____ SOCIAL SECURITY #: _____
CITY, STATE, ZIP: _____ HOW LONG AT THIS ADDRESS: _____
PREVIOUS ADDRESS, IF LESS THAN TWO YEARS: _____

RACE: ☐ WHITE ☐ BLACK ☐ HISPANIC ☐ OTHER: _____

SEX: ☐ MALE ☐ FEMALE

MONTHLY INCOME STATEMENT:

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED

NAMES AND AGES OF DEPENDENTS: _____

PLEASE ATTACH A COPY OF LAST YEAR'S W-2 FORM AS PROOF OF INCOME
If last year's income is not representative of your current situation or if you own property or resources in excess of one homestead and one vehicle, please also attach a complete explanation.

OFFICE USE ONLY

Name and policy number of health insurance: _____

Date Medicaid application was filed and status: _____ ☐ Pending ☐ Denied ☐ Approved

Date Social Security Disability application was filed and status: _____ ☐ Pending ☐ Denied ☐ Approved

I recognize that the Department of Health may have need to review medical records relating to my HIV status. My signature below confirms my agreement to apply for the AZT program and my consent that all parties in control of my Medicaid application, Social Security Disability application, and other medical records release such records to the bearers of this document. The Health Department also has my consent to work with Medicaid and Social Security to speed determinations by those agencies and may share information gathered in this application process with those persons handling my Medicaid and Social Security Claims.

SIGNATURE AND DATE

I certify that the income statements attached to this application are true and current. I have also attached a complete disclosure of all resources in excess of one homestead and one vehicle.

SIGNATURE AND DATE

OFFICE USE ONLY

DATE RECEIVED _____

DATE APPROVED _____

DATE CLOSED: _____

REASON FOR CLOSURE: _____



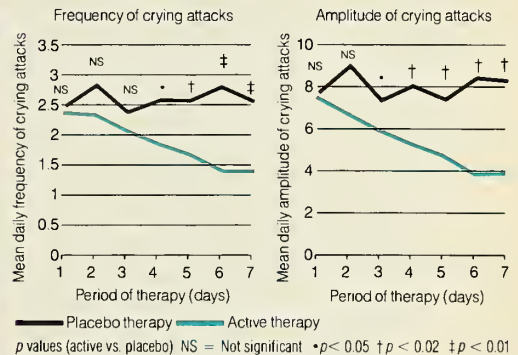
Family therapy for colic.

The excessive crying of colic puts a strain on the most loving family—and often on their physician as well. And whatever the cause of colic, one fact is clear:

Gas is often part of the colic problem.

New Phazyme Drops contains simethicone, which can safely break up gas and bring baby relief. That's why it can help whenever colic is a problem.

Significantly reduces crying of colicky infants.¹



Double-blind, randomized, placebo-controlled study.

Priced 25% below the leading brand.

This significant price advantage will be particularly important to parents, since they may be relying on Phazyme Drops for up to three months. And it's naturally flavored—something else they'll appreciate.

NEW 
Phazyme Drops (simethicone/
 antigas)
**Helps you through
 the colic phase.**

1. Kanwaljit SS, Jasbir KS. Simethicone in the management of infant colic. *Practitioner*. 1988;232:508.

REED & CARNICK
 Piscataway, NJ 08855

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PZ24

Things To Come

August 30-September 1

Keys to Successful Peripheral Intervention:

Balloon, Stent, Atherectomy, and Laser. Sponsored by the Cardiovascular Institute of the South, Houma, LA. Windsor Court Hotel, New Orleans, LA. For more information, contact Jane Arnett at 1-800-525-8777.

September 10-14

Physician in Management I&II. Sponsored by the

American College of Physician Executives, Tampa, FL. Four Seasons Hotel, Newport Beach, CA. CME credit available. For more information, call 1-800-562-8088.

October 14-17

SMA's 84th Annual Scientific Assembly. Presented

by the Southern Medical Association, Birmingham, AL. The Opryland Hotel, Nashville, TN. Hour-for-hour Category 1 credit available. Fees: \$50.00, SMA mem-

bers; \$150.00, non-members. For more information, contact Kathy McLendon at 1-800-423-4992.

November 15-18

37th Annual Meeting of the Academy of Psychosomatic Medicine. The Pointe at Squaw Peak, Phoenix, AZ. For more information, call (312) 784-2025.

November 25-30

RSNA Scientific Assembly and Annual Meeting.

McCormick Place, Chicago, IL. For more information, call Jodi Skrip at (312) 558-1770.

December 3-7

Physicians in Management I. Sponsored by the

American College of Physician Executives, Tampa, FL. Hyatt Regency Sarasota, FL. CME credits available. For more information, call, 1-800-562-8088.

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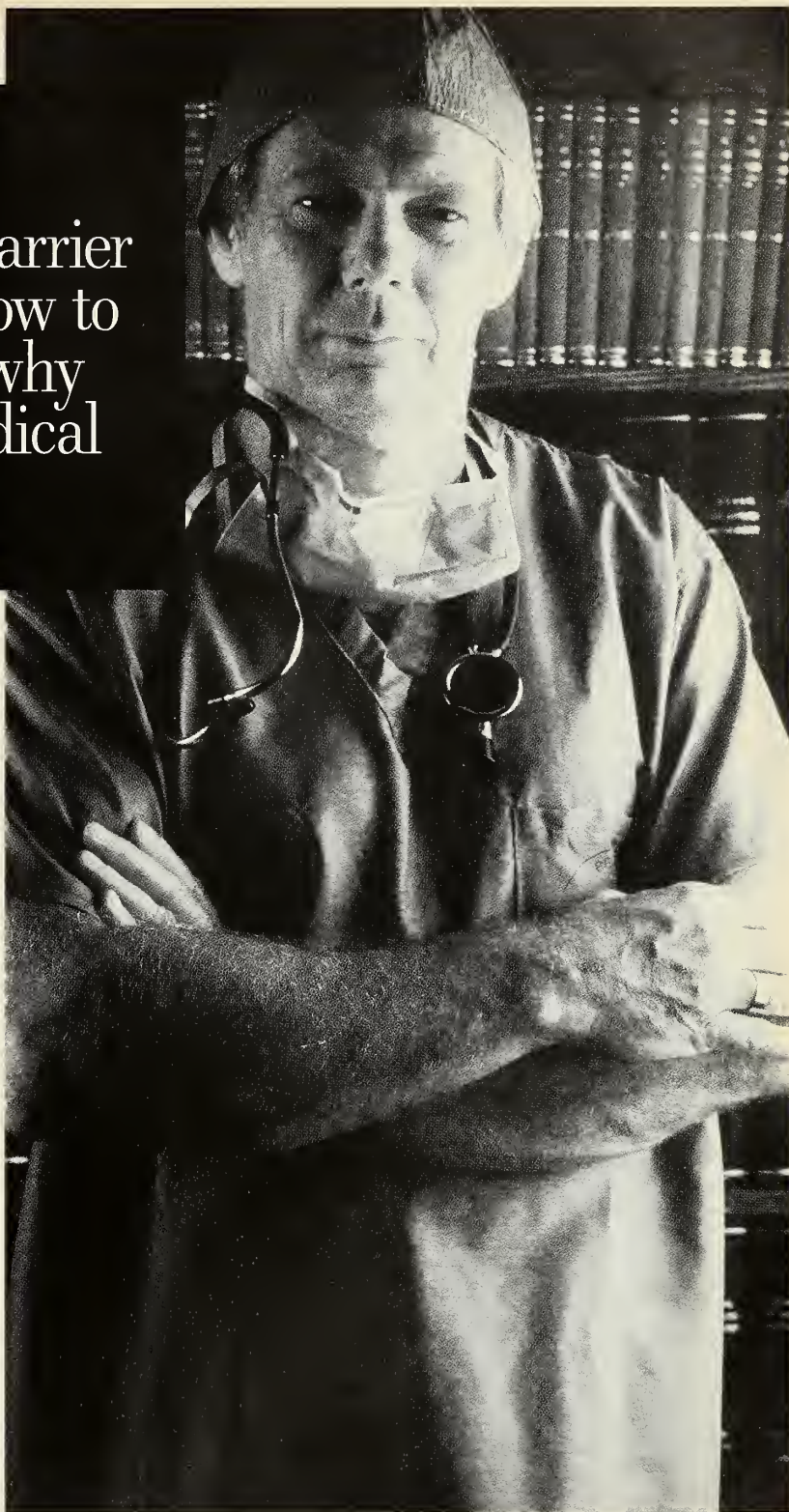
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(800) 322-6616

Keeping Up

Advances in the Management of Essential Hypertension including Target Organ Involvement

August 24, 12:00 noon. Presented by AHEC-Fort Smith. Speaker: Edward Frohlich, M.D. Sparks Regional Medical Center, 7th floor dining room. One Category I credit hour. Free admission.

Arkansas Heartsong Retreat for HIV Plus!

September 10-13. Presented by the Arkansas AIDS Interfaith Council and Arkansas Office of RAIN (Regional

AIDS Interfaith Network). 4-H Center, Little Rock. For more information, call the Christ Episcopal Church at (501) 375-5908.

Loss Prevention Seminar

October 20, 8:00 a.m.-11:00 a.m. and 12:00 noon-3:00 p.m. Presented by State Volunteer Mutual Insurance Company and co-sponsored by the Arkansas Medical Society. Fayetteville Hilton, Fayetteville. Two Category I credit hours. Free admission. For more information, call 1 (800) 633-3215 or (615) 377-1999.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

Continuing Medical Education Luncheon, third Friday, 12:30 p.m. AMI Ozark-Quapaw Room. One Category I credit per meeting.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), third Wednesday, 12:30 p.m., Conference Room, Building 1, VAMC
Mortality/Morbidity Conference, fourth Wednesday, 2:45 p.m., Conference Room, Building 1, VAMC

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Faculty Resident Seminar, third Thursday, 12:00 noon, Sturgis Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Building, Room 457
Infectious Disease Conference, second Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Building, Auditorium
Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., 2nd Floor Classroom
Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, 2nd Classroom
Pediatric Research Conference, first Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

Interdisciplinary AIDS Conference, second Friday, 12:00 noon. LaHarpe Room. Sandwich buffet is served.
Cancer Conference, third Thursday, 12:00 noon, Laboratory Conference Room. Lunch is provided.
Hematology-Oncology Conference, second Thursday, 12:00 noon, Laboratory Conference Room. Lunch is provided.
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Southwestern Bell/Arkla Room. Refreshments are provided.
Pulmonary Conference, second and fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla Room. Sandwich buffet is served.
Journal Club, every Tuesday, 12:00 noon, Conference Room 1. Lunch is provided.
GYN Surgery Cancer Conference, second Monday, 12:00 noon, AP&L Room. Lunch is provided.
Joint Tumor Conference, first Wednesday, 12:00 noon. CARTI Auditorium. Lunch is provided.

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., Conference Room 1
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lectures and case presentations. A light lunch is provided.
Pathology Conference, third Tuesday, 3:00 p.m., Pathology Library
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. A light lunch is provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC/CARTI Tumor Conference, Wednesdays, 12:00 noon, CARTI Auditorium, Markham & University
ACRC Oncology Forum, fourth Thursday, 4:00 p.m., UAMS ACRC 2nd Floor Conference Room, 1.5 credits
ATLS Provider Course, July 28-29. UAMS Education Building
Anesthesia Conference Series, Wednesdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
Anesthesia Morbidity and Mortality Conference, second and fourth Tuesdays, 6:45 a.m.; first, third and fifth Thursdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy
Child Psychiatry Clinical Case Conference, first Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Child Psychiatry Research Review, fourth Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Dermatopathology Conference, Tuesdays, 8:00 a.m., UAMS Education Building, Room G/108 A&B
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Building, Room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Building, Room G/110A&B
Emergency Medicine Grand Rounds 1, third Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Grand Rounds 2, third Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Morbidity and Mortality Conference, fourth Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Radiology Conference, fourth Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Conference, first Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Rounds, first Tuesdays 3:00 p.m., UAMS Education Building, Room B/106A&B
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology Conference Room, #M1/293.
Interdisciplinary Gynecologic Cancer Conference, Fridays, 12:30 p.m., UAMS Education Building, Room G106 A&B
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Building, Room G/131A&B
Medicine Research Conference, three Wednesdays per month, 4:30 p.m. Shorey Building, Room 3S06
Neurology Clinical Case Conference, Thursdays, 8:00 a.m. Rotates between UAMS (7D33) and LRVAMC (3S) and ACH
Neuropathology Conference, Thursdays, 10:00 p.m. UAMS Autopsy Room
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Ob/Gyn Grand Rounds, Wednesdays, 8:00 a.m., UAMS Education Building, Room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, Room 3/150, 2 credit hours
Orthopaedic Basic Science Conference, occasional Tuesdays, 11:00 a.m., UAMS Education Bldg., Room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Building, Room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Building, Room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Building, Room B/135
Pathology Autopsy Conference, Mondays, 9:05 a.m., LRVAMC Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
St. Vincent Urology Grand Rounds, first Tuesday, 5:30 p.m., St. Vincent Infirmary, Education Building, Room 159
Surgery Basic Sciences Conference, first Wednesday, 4:00 p.m., UAMS Education Building, Room G/141
Surgery Morbidity and Mortality Conference, Wednesdays, 7:00 a.m., UAMS Education Building, Room G/141A
Surgery Staff/Clinical Case Conference, alternating Tuesdays, 7:00 a.m., UAMS Education Building, Room G/141/
Surgery Review Conference, every second, third and fourth Wednesday, 4:00 p.m., UAMS Education Building, Room G/141
Urology Basic Sciences Conference, second Tuesday, 5:00 p.m., UAMS Education Building, Room G/106A&B
Urology Clinical Didactic Conference, third Tuesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Core Conference, once or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Grand Rounds, second and fourth Tuesday, 5:00 p.m., VAMC-LR (4D)
Urology Morbidity and Mortality Conference, last Wednesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Teaching Conference, one or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Uro-Radiology Workshop (Urologic Imaging), once monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
VA Chest Conference (combined Surgical/Medical Chest Conference), alternating Mondays, 12:15 p.m., VAMC-LR, Room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine Conference Room, Room 1D173
VA Hematopathology Conference, Wednesdays, 3:00 p.m., LRVAMC Conference Room
VA Lung Cancer Conference (combined Medical/Surgical Lung Cancer Conference), Tuesdays, 3:00 p.m., LRVA, Room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Building 68
VA Physical Medicine and Rehab Grand Rounds, fourth Friday, 11:00 a.m., VAMC-NLR Building 68, Room 118 or Arkansas Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, Room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine, Thursdays, 8:00 a.m., VAMC-NLR Building 68, Room 118

VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology Conference Room
Vascular/Radiology Conference, Thursdays, 7:00 a.m., LRVAMC Radiology Conference Room
Vascular Teaching Conference, Thursdays, 8:00 a.m., LRVAMC Radiology Conference Room.

EL DORADO - AHEC

Behavioral Sciences Conference, first and fourth Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, second Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second and fourth Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, fourth Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, first, second and third Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

Cardiology Lecture Series, first Monday, 1:00 p.m., Washington Regional Medical Center
City Hospital Staff Meetings, second Friday, 12:00 noon, Fayetteville City Hospital
Family Medicine Conference, each Tuesday and Wednesday, AHEC - NW, 241 W. Spring, Fayetteville
Internal Medicine Conference, each Tuesday, 12:00 noon, Washington Regional Medical Center

FORT SMITH - AHEC

Internal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first and third Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, June 22, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.
Chest Conference, second Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided
Cleburne County Medical Society, second Thursday, 12:00 noon, Cleburne Memorial Hospital - Herbert L. Thomas Conference Room, Heber Springs
Eaker AFB CME Conference, second and third Wednesday, 12:00 noon or 4:00 p.m., Hospital Cafeteria
Independence County Medical Society, second Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, fourth and fifth Tuesday, 12:00 noon, St. Bernards Dietary Conference Room. Lunch provided.
Jackson County Medical Society, third Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, third Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, second Tuesday, 7:30 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neurological-Neurosurgical Conference, first Monday, 12:00 noon, St. Bernard's Dietary Conference Room
Neuroradiology Conference, third Friday, 12:00 noon, St. Bernards Dietary Conference Room. Lunch provided.
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Pocahontas CME Conference, third Wednesday, 12:00 noon and 7:30 p.m., Randolph County Medical Center Boardroom
Walnut Ridge CME Conference, third and last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
West Plains CME Conference, fourth Wednesday, 6:30 p.m., West Plains Country Club, West Plains, MO

PINE BLUFF-AHEC

Behavioral Science Conference, first and third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second and fourth Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, first and fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, second and fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second and fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Cine Radiology, second Friday, 12:00 noon, Wadley Regional Medical Center.

Echo-Cardiology, fourth Friday, 12:00 noon, Wadley Regional Medical Center
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Neuro-Radiology Conference, first and third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

Medicine in the News

Reminder: AMA Gets New Headquarters

The American Medical Association has moved its headquarters to a new building and will have a new address beginning August 16 and new phone number beginning August 27.

American Medical Association
515 North State Street
Chicago, IL 60610
(312) 464-5000

winners of the first five History of Medicine Associates Research Awards. Each of the papers provide information about a different aspect of Arkansas health care.

Copies of the book are available, prepaid only, from:

History of Medicine Associates
c/o Special Collections
UAMS Library, Slot 586
4301 West Markham
Little Rock, AR 72205-7186

The History of Arkansas Medicine

The History of Medicine Associates of the UAMS Library, with assistance from the Arkansas Endowment for the Humanities, has recently published *Contributions to Arkansas Medical History*. The papers included are the

The cost of the book is \$15.00 plus a \$2.00 postage and handling fee. There is a special price for associate members.

The History of Medicine Associates is a support group for the Special Collections Division of the UAMS Library which includes historical books, photographs, and archival materials.

In Memoriam

Don W. Chamblin, M.D.

Don W. Chamblin, M.D., of Fort Smith, died Thursday, June 21, 1990. He was 69.

Dr. Chamblin was a retired anesthesiologist with Holt-Krock Clinic and a member of the Arkansas Medical Society.

Dr. Chamblin is survived by his wife, Mrs. Marge Chamblin; a son, Don "Buzz" Chamblin Jr. of Fort Smith; a daughter, Lynnda Wise of Van Buren; and two grandchildren.

Recruiting Physicians

Growing community hospital of 63 beds in the scenic Ozark Mountains in N.W. Arkansas is seeking full time, experienced emergency physicians to staff low volume E.D. Must be BP/BC in EM, FP, or IM with ACLS. \$110K+/yr. Flexible scheduling. Part-time also available. Send C.V. to: W. Mulchin, M.D., FACEP
602 Walton Blvd.
Bentonville, AR 72712
(501) 273-2481

AMS Newsmakers

Thomas W. Atkinson, M.D., an internist in Siloam Springs, was elected incoming president of the American Heart Association at a recent meeting in Bentonville.

Raymond V. Biondo, M.D., of the North Little Rock Dermatology Clinic, recently received the third Father Joseph Biltz Award ever presented by the Arkansas Council of the National Conference of Christians and Jews.

Scott C. Claycomb, M.D., of Warren, recently received the Lange Award, given by the UA Medical Center to senior students with superior academic achievement.

O.H. Clopton, M.D., of Jonesboro, who specializes in internal medicine, has assumed the position of president of the Arkansas Thoracic Society.

Thomas R. Dykman, M.D., of Fayetteville, received a Distinguished Service Award for outstanding volunteer work with the Arkansas Chapter of the Arthritis Foundation.

Durwood W. Flournoy, M.D., of El Dorado, has been named chief of staff for the Medical Center of South Arkansas.

Dr. Flournoy is a clinical instructor for UAMS medical students and residents through the AHEC of South Arkansas.

John C. Henderson, M.D., F.A.C.C., of Searcy, was formally inducted as a fellow of the American College of Physicians in Convocation Ceremonies held recently in Chicago.

Dr. Henderson practices cardiovascular medicine and is on staff at the Central Arkansas Hospital and the White County Memorial Hospital.

William E. Knight, M.D., of Fort Smith, recently announced his retirement from the speciality of Orthopaedic Surgery. He has been in active practice of the specialty for 41 1/2 years with Holt-Krock in Fort Smith.

James Y. Suen, M.D., professor and chairman of the department of Otolaryngology and Maxillofacial Surgery at UAMS, recently received the "Distinguished Faculty

Award" presented by the University's College of Medicine and the Arkansas Caduceus Club.

Thomas E. Townsend, M.D., of Pine Bluff, was recently presented the "Distinguished Alumnus Award" by the University of Arkansas for Medical Sciences College of Medicine and the Arkansas Caduceus Club.

Dr. Townsend currently serves as a clinical professor of pediatrics and has been instrumental in the education of hundreds of medical students.

William Webb, M.D., of Fort Smith, who specializes in pulmonary medicine with the Cooper Clinic, has been elected to the board of advisors of St. Edward Mercy Medical Center.

Physicians Recognition Award

The Physician's Recognition Award is awarded each month to physicians who have completed acceptable programs of continuing medical education. The recipients for the month of June are:

Braden, Lawrence F.	Camden
Bredfeldt, Raymond C.	Fayetteville
Campbell, James W.	Hot Springs
Dykstra, Peter C.	Mountain Home
Flanigan, Stevenson	Little Rock
Greenway, Curtis D.	Little Rock
Hobby, George A.	Paragould
Hof, Charles W.	Rogers
Jordan, Randy A.	Little Rock
Lang, Nicholas P.	Little Rock
Langston, Harold D.	Little Rock
Maglothlin, Douglas L.	Jonesboro
Mahoney, Paul L.	Harrison
Marsh, James W.	Warren
Maruthur, Gopakumar	Hot Springs
Pike, John D.	Little Rock
Roberts, David H.	Mountain Home
Smith, Mose	Little Rock
Smith, Ronald D.	Blytheville
Wells, Charles F.	Morrilton

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New Members

BENTON COUNTY

Carrington, Patrick R., Dermatology, Rogers. Born March 8, 1951, Alexandria, LA. Medical education, Louisiana State University, Natchitoches, LA, 1973. Internship/residency, LSU Medical Center, Shreveport and Tulane Medical Center, New Orleans, 1983. Practice experience, 6 years. Board certified.

FAULKNER COUNTY

McCarron, Robert F., Orthopaedic Surgery, Conway. Born October 31, 1952, Hot Springs. Medical education, UAMS, 1977. Internship, UAMS, 1978. Residency, Texas Tech University, Lubbock, TX, 1982. Practice experience, 8 years. Board certified.

PULASKI COUNTY

Arnold, David M., Orthopaedic Surgery, Little Rock. Born December 29, 1956, Minneapolis, MN. Medical education, St. Louis University School of Medicine, MO, 1983. Internship, Mayo Clinic Department of Orthopedics, Rochester, MN, 1988. Residency, Spine Fellowship, Wiltse Spine Institute, Long Beach, CA, 1989. Board certified.

Newton, Fred E., OB/GYN, Little Rock. Born April 1, 1958, Dallas, TX. Medical education, UAMS, 1986. Internship/residency, Tulane Medical Center, New Orleans, LA, 1990. Board eligible.

Paddock, George O., Ophthalmology, Jacksonville. Born October 22, 1945, Elmhurst, IL. Medical education, UAMS, 1970. Internship, University of Cincinnati Hospital, OH, 1971. Residency, Indiana University Medical Center, Indianapolis, IN, 1977. Board certified.

Singer, Peter G., Dermatology, North Little Rock. Born July 17, 1957, Detroit, MI. Medical education, St. Louis University, MO. Internship/residency, UAMS, 1990. Pending certification.

Smelz, Johnny K., Physical Medicine & Rehabilitation, Little Rock. Born May 12, 1945, San Antonio, TX. Medical education, Georgetown University School of Medicine, Washington, D.C., 1982. Internship/residency, University of Texas at San Antonio, 1985. Board certified.

Wooten, Virgil D., Psychiatry, Little Rock. Born March 1, 1954, Siloam Springs. Medical education, UAMS, 1980. Internship/residency, UAMS, 1984. Board certified. Practice experience, 5 years.

Yamauchi, Terry, Infectious Diseases, Little Rock. Born May 30, 1941, Portland, OR. Medical education, University of Oregon, Portland, 1963. Internship/residency, UCLA-Harbor General Hospital, Torrance, CA, 1970. Practice experience, 20 years. Board certified.

SEBASTIAN COUNTY

Phillips, Sumer A., Internal Medicine, Fort Smith. Born August 23, 1959, Jeruslaem, Israel. Medical education, University of Missouri, Kansas City, 1984. Internship, University of Kansas, Wichita, 1986. Residency, University of Kansas, Kansas City, 1988.

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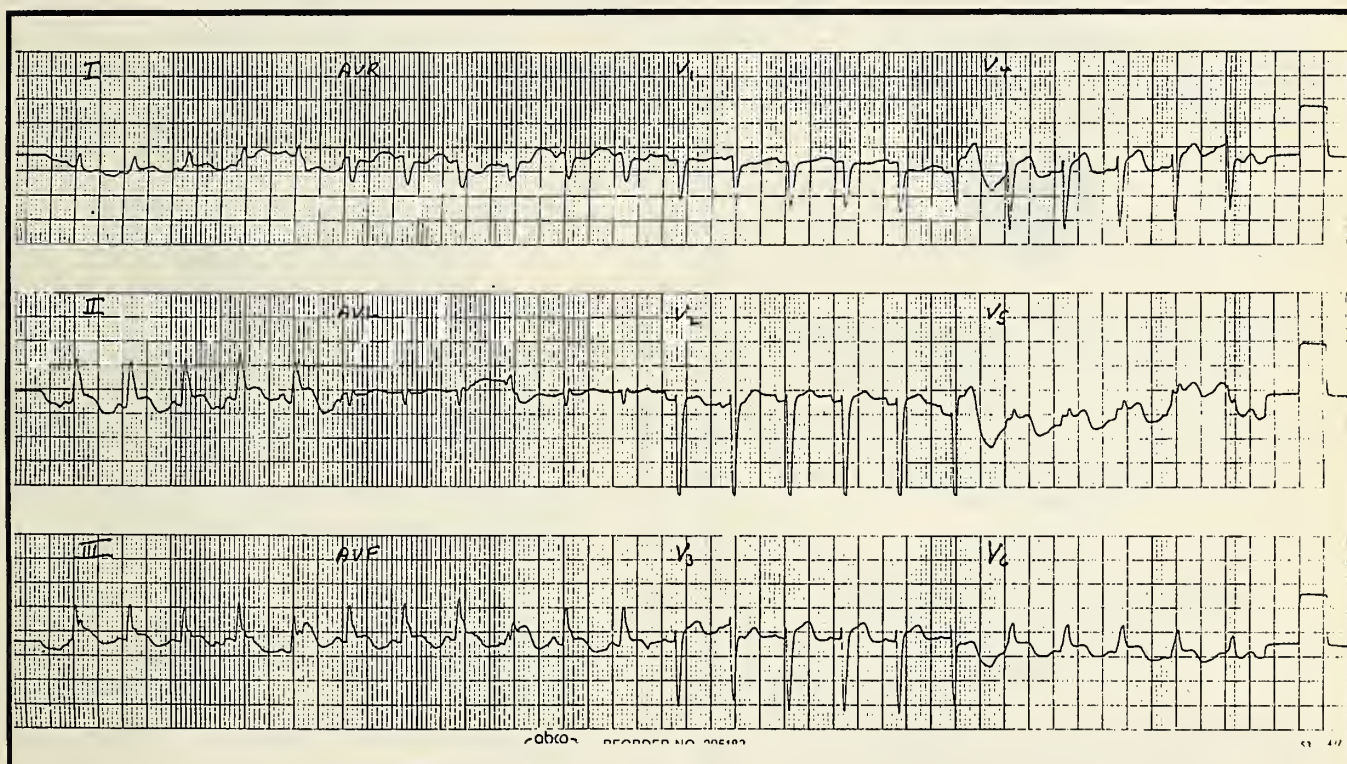
ELECTROCARDIOGRAM of the MONTH



William C. Roberts, M.D.
John W. Watson, M.D.

CLINICAL HISTORY:

V.D. is a 50-year-old man who experienced the onset of crushing substernal chest pain associated with diaphoresis two hours prior to presentation to the hospital. Cardiovascular examination revealed hypotension, crackles in the lungs, and a ventricular gallop. An echocardiogram showed inferior and lateral wall hypokinesis. What do think about the trace and potential subsequent therapy?



DISCUSSION:

The ECG shows sinus tachycardia and ST-T changes compatible with acute inferior and lateral infarction. In the absence of contraindications to such treatment, one would be obligated to give due consideration to thrombolytic therapy.

The editor wishes to thank Dr. Roberts of Conway for his contribution to this month's featured electrocardiogram.

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Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: Angioedema. Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hypotension, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, Drug Interactions and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: General: Impaired Renal Function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (>5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See Drug Interactions.)

Surgery/Anesthesia: In patients undergoing major surgery or under anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyl-dopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy—Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Salt supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50-times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not

been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of 14 C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, Hypotension); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances: atrial fibrillation, palpitation.

Digestive: Ileus, pancreatitis, hepatitis (hepatocellular or cholestatic jaundice), melena, anorexia, dyspepsia, constipation, glossitis, stomatitis, dry mouth.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, hyperhidrosis.

Special Senses: Blurred vision, taste alteration, anosmia, tinnitus, conjunctivitis, dry eyes, tearing.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgias, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately (see WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings:

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: Hypertension: In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses: in some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).


Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤ 30 mL/min (serum creatinine ≥ 3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, Pharmacodynamics and Clinical Effects.) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Patients with Heart Failure and Renal Impairment or Hyponatremia: In patients with heart failure who have hyponatremia (serum sodium <130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, Heart Failure, WARNINGS, and PRECAUTIONS, Drug Interactions.) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

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Arkansas Medical Society News, June 8, 1990

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On our cover: The photograph was provided by the American Cancer Society. It is a reprint of one of their anti-smoking posters.

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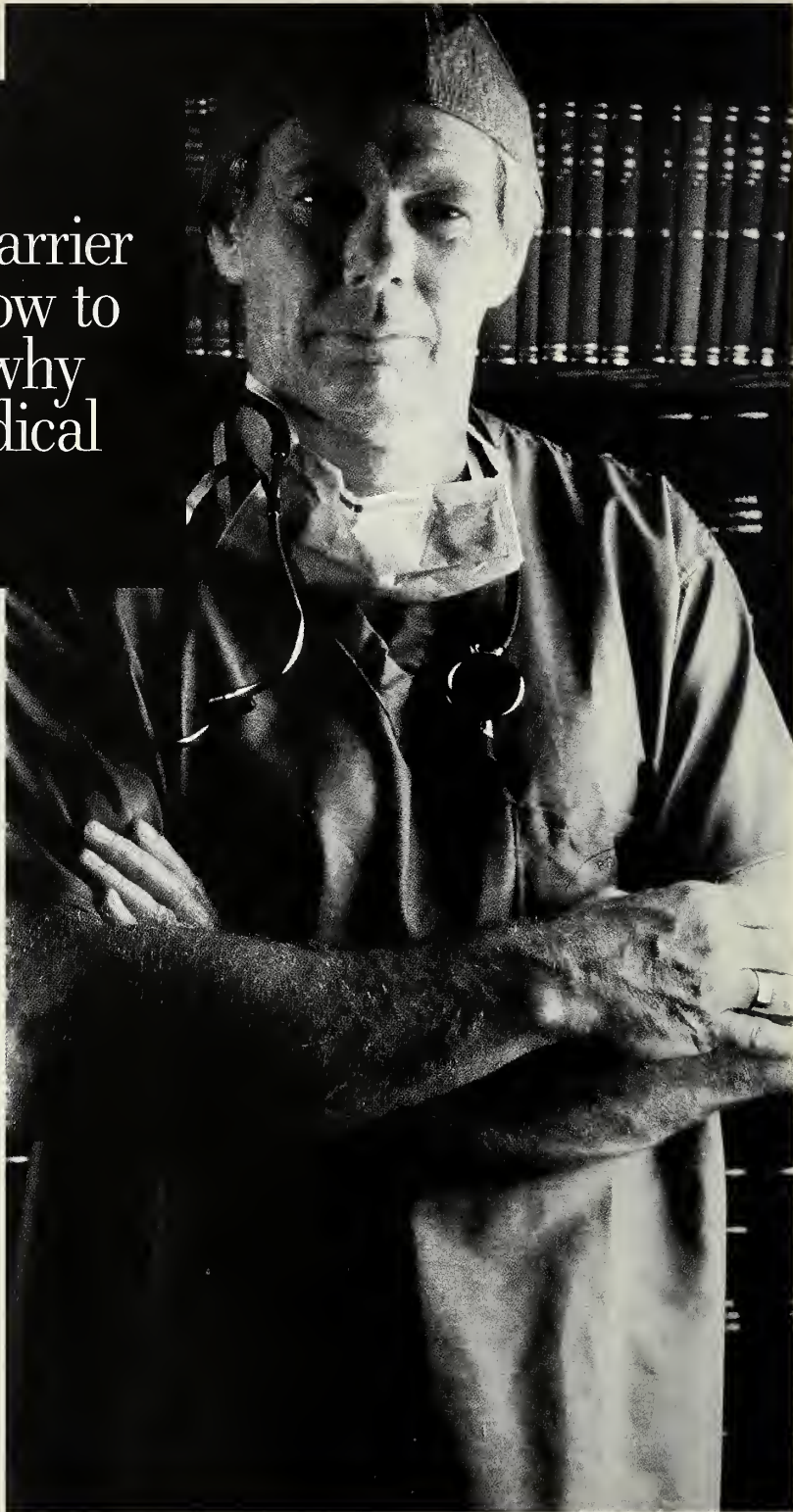
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Report of the Smoking & Tobacco Products Committee

David L. Rogers, M.D.*

The concept for the Smoking & Tobacco Products Committee was developed by William N. Jones, M.D. several months before he was inaugurated as the current president of the Arkansas Medical Society. Inspired by C. Everett Koop, M.D., who as Surgeon General proposed a smoke-free society by the year 2000, and supported by a resolution adopted by the AMS House of Delegates in 1987, Dr. Jones asked me to chair a committee that would establish short-term and long-term goals which would help bring about a smoke-free society. Committee members include Drs. Lloyd Langston, Gail McCracken, David Harshfield, Brenda Powell, Kelsey Caplinger, Ben Owens, Steve Schoettle, Loved Peacock, and Rick Harrison.

At our organizational meeting in June of this year, the committee developed three major goals. The first goal was to arrange for the presentation of a seminar, sponsored by the National Cancer Institute, entitled "How To Help Your Patients Quit Smoking." This seminar will provide educational and training material so that each physician will be able to not only help his own patients to quit smoking, but also to teach the technique to other physicians in his or her county medical society or hospital staff. This seminar will be offered later this year and specific information will be mailed to you.

Our second goal is to work with Lynn Zeno and the Governmental Affairs Committee to develop legislation for the 1991 legislative session. These bills would encourage an increase in tobacco excise taxes, outlaw the sale of cigarettes in vending machines, ban the practice of providing free samples of smokeless tobacco products, prohibit smoking in schools, health care facilities and public buildings, and prohibit pharmacies in Arkansas from selling cigarettes.

Our third goal is to educate the general public on the health dangers and economic disadvantages of tobacco use. In order to accomplish this, we must first educate ourselves. Each committee member will collect data and report on

various aspects of smoking and tobacco use in upcoming *Journals*. As physicians, we are the natural professionals to become the leaders in helping the people of Arkansas - our patients - to understand the risks of tobacco use, and to either convince them never to start smoking or to help them quit.

We hope to eventually establish an education program in the public schools, probably in conjunction with the Arkansas Department of Education and the Arkansas Department of Health. This program should be aimed at children at the grade school level, since more than 90% of all smokers begin smoking as a teenager or younger, and 25% of all high school seniors who smoke begin before or during the sixth grade.

Our committee believes it is time for the physicians in Arkansas to assume the leadership role in accomplishing these goals. Becoming a smoke-free society is an issue whose time has come. No one can dispute the health risks of tobacco. If we truly have our patients' health as our primary concern, then we will gladly accept this leadership and we will be successful.



* Dr. Rogers is a family physician at Washington Regional Medical Center in Fayetteville and chairman of the Smoking & Tobacco Products Committee of the Arkansas Medical Society.

Rural Health Care: An Arkansas Crisis for the Millennium?

I. Dodd Wilson, M.D.*

All Americans have the right to access to health care. In some parts of rural Arkansas, this access is in jeopardy. Whereas 25% of the nation's population is defined as rural, the percentage of rural Arkansans is undoubtedly higher.

Concerns about rural medical practice in Arkansas are greater now than at any time during the previous three years of my deanship. Physicians provide the foundation for rural health care. Fifty of 75 Arkansas counties are totally or partially designated as primary health manpower (physician) shortage areas. Thirty-three counties contain areas designated to be of greatest need, defined as having no primary care physician or a ratio of population to primary care physicians of greater than 5000:1. During the past decade, the number of physicians in the nine rural Arkansas counties with population less than 10,000 declined from 26 to 24¹. Eleven rural Arkansas hospitals closed between 1985 and 1990 and ten additional rural hospitals are in danger of closing.

Many factors contribute to attracting and retaining physicians in rural practices. The health of the local economy is extraordinarily important. Low population density may make an economically-viable medical practice impossible. Other determinants of the development of a successful, sustainable practice in a rural setting include the quality of the local school system, access to a hospital, the ability of the community leadership, malpractice concerns, the potential of practicing in a group rather than alone, and the availability of other health professionals.

Interest of medical students nationally in primary care and in rural practice waned during the last decade. The percentage of graduating medical students from all American medical schools entering a primary care specialty fell from 38.8% to 25.4%. Those entering family practice declined from 17.3% to 13.7%. The preference of graduating seniors for practice settings in either rural towns having less

than 10,000 population or unincorporated rural settings dropped from 9.3% to 4.4% during the same period². Clearly, these numbers do not bode well for future placement of physicians in rural Arkansas.

Most rural health care is delivered by family physicians. Therefore, another problem is the relative lack of family physicians in training. The number of family practice residency positions remained static nationally during the 1980's while residency positions offered in other specialties rose by 1,770 openings. From 1984 to 1990, the family practice residency positions filled through the residency match dropped from 85.2% to 70.4%. It seems likely, given the data regarding preferences for practice settings, that fewer of these graduates will choose rural practice.

UAMS has a proud and strong record in education for rural medical care. It is sixth out of 127 medical schools in percent of its graduates from 1970-1979 who practice family medicine and eleventh in graduates who remain in state (unpublished AAMS data). Between 1981 and 1988, our College of Medicine was seventh in the percentage of graduates entering family practice³. We continue to do well.

In Arkansas, between 1979 and 1989, the number of practicing physicians increased by 913 (+37%) while primary care physician numbers were up 535 (+52%). Physicians in the 17 rural counties with populations between 10,000 and 15,000 increased from 67 to 86 (+30%). In 14 counties having between 15,000 and 20,000 inhabitants, the increase of physicians was even greater (+34, +43%). Even though 50 counties now contain shortage areas, this is a marked improvement over the early 1970's when 74 of 74 counties were designated "medically underserved"⁴. Much of this good record is attributable to policies of the College of Medicine and to the geographically dispersed family practice residency programs offered through the AHEC system and the College.

Despite evidence that availability of physicians has improved in much of rural practice, the troubled rural economy and the declining interest of students in primary care and

* Dr. Wilson is the dean of the College of Medicine at the University of Arkansas for Medical Sciences in Little Rock.

rural practice are disturbing indications that continued improvement will be difficult. What should be done to address this problem? Suggestions are divided into two lists, those actions by UAMS and action that will require the sponsorship of others.

For UAMS I suggest:

1. Targeted recruitment of outstanding applicants from rural communities. Students from rural communities are more likely to enter rural primary care practice. We need the help of the Arkansas Medical Society and rural physicians to accomplish this.
2. Expansion of family medicine academic programs by adding a mandatory third year clerkship. Existing programs, which provide exposure to family medicine and rural health care, and already are well received by students, are preceptorships after years one and two, the Introduction to the Medical Profession course, the Family Practice Club, and the required fourth year primary care selective.
3. Provision of expert technical and management consultation support for selected rural hospitals.
4. Improved support of rural physicians through on-site continuing education and, if requested, consultation.
5. Strengthening of the Department of Family and Community Medicine under the leadership of Geoffrey Goldsmith, M.D.
6. Development of one or more model rural practices in areas of highest need under sponsorship of UAMS.
7. Enhanced recruitment of medical school graduates into the six family medicine residencies in Arkansas.

Needed from others:

1. Revision of the reimbursement system for physicians so that practice becomes economically more feasible

in rural Arkansas. The resource based relative value scale represents a small advance in this direction.

2. Incentives, both federal and state, for rural practice. The state incentive of \$6,000 per year for five years for rural practice should be increased and low-cost loans should be provided to equip and develop a practice.
3. Support for adequate patient transportation systems to make rapid access to emergency care available.
4. Legislation to eliminate the malpractice disincentive to provision of obstetrical care in rural communities.
5. Reinstitution of the National Health Service Corps which placed so many physicians in rural areas having great need.
6. Revision of the existing state rural physician scholarship and loan program to provide greater incentives to practice in rural communities.

Through the combined efforts of federal, state, and local governments, UAMS, the Arkansas Medical Society, the Arkansas Academy of Family Physicians, and the communities involved, we can find solutions to sustain the positive trends that have occurred in Arkansas during the past two decades.

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A Surgeon Looks Back

David S. Bachman, M.D.*

Thirty years of surgical practice, 2,500 operations, and four years of retirement should allow one to look back and reminisce. So many things have happened in surgery during the past 30 years - some good and some bad.

Our greatest public health problem in the early 1960's was the morbidity and mortality from cigarette smoking - especially lung cancer. A few of us felt that cigarettes were a drug related addiction. We were voices in the wilderness. Sixty percent of the public smoked. The non-smokers were in the minority. Little was written concerning smoking and disease. The Surgeon General's report on Smoking and Health in 1964 was the first monumental advance in smoking education in the United States.

In the 1960's, T and A was the standard procedure before entering school. Breast cancers were treated via mutilating radical mastectomy. Wangenstein even championed a super radical mastectomy that included a modified neck dissection. Some zealous surgeons advocated radical mastectomy with chest wall resection.

Peptic ulcer surgery consisted of three-fourth gastrectomy. In those days, it seemed we surgeons thought radical surgery was paramount to survival. Something like using a baseball bat to kill a fly.

Organ transplant was experimental. Coronary bypass surgery was in it's infancy. Surgery for tuberculosis was radical and mutilating. Three stage thorocoplasty was in vogue. Rigid tube bronchoscopes and esophagoscopes were instruments of the devil. Getting a patient to submit to a second scoping was a job of super salesmanship.

In the Philadelphia, Pennsylvania area, stainless steel sutures were quite popular. One of our local surgeons in Allentown, Pennsylvania, trained in Philadelphia and a disciple of the steel dictum, was almost run out of town when his resident cut the wire suture too long on a anterior and posterior vaginal repair.

Diagnostic procedures were unsophisticated - upper and lower GI procedures, bronchography, IVP's, etc. Mammography, CAT scans, MRI, and Positron Emission Tomography weren't even dreamed of.

Those days, general surgeons were general surgeons. Sub-specialties soon began their relentless hacking away

at the general surgeons bailiwick.

Surgeons were held in high esteem by the public. Most diagnoses were made clinically. Laboratory procedures were mainly used as backup procedures. An occasional surgeon would use a battery of tests, but he was the exception. Malpractice cases, when filed, were usually legitimate. Even though we didn't have the sophisticated diagnostic procedures, it was a pleasure to practice surgery "in the good old days."

My how things have changed! Rampant malpractice suits, exorbitant malpractice insurance fees, zillions of diagnostic procedures, third party interventions, tons of unnecessary paper work, and the necessity of practicing defensive medicine - having to order a battery of unnecessary laboratory and diagnostic procedures to satisfy some greedy malpractice attorney.

Sad but true, the esteem of my surgical colleagues has been tarnished. Some of the public, especially attorneys, view them as money hungry egotistical bastards playing God to the enth degree. Patient rapport still seems to be the best way to keep patients happy.

Unfortunately, one thing hasn't changed. We're still not curing lung cancer. Cigarettes are killing 395,000 people every year. Abstinence from smoking and tobacco use is the keyword to health and longevity.

Hopefully, a young surgeon reading this article today will reflect back 30 years from now and say "remember when people smoked - even chewed and used snuff?"

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* Dr. Bachman practiced as a general surgeon and bronchoesophagologist at the Millard Henry Clinic for 20 years. He retired in 1986 and now resides in Dardanelle, Arkansas.

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Interpreting The Cruzan Case For Arkansas

Chris Hackler, Ph.D.*

Anne Owings Wilson, J.D.**

The United States Supreme Court decided its first "right to die" case on June 25, 1990.¹ The issue was whether artificially administered nutrition and hydration could be withdrawn from Nancy Beth Cruzan, a patient in a permanent vegetative state. The Court let stand the Missouri Supreme Court decision² that food and water could not be withdrawn. The Missouri court had based its ruling on the lack of "clear and convincing evidence" that Cruzan would have wanted treatment discontinued. In the absence of such evidence, the Missouri court stated, the state's "strong interest in the preservation of life" required the continuation of treatment. Without endorsing Missouri's standard, the U.S. Supreme Court found that Cruzan's rights were not unconstitutionally infringed by Missouri's decision. The present article examines the implications of this important decision for the practice of medicine in Arkansas.

The Case

Brief Facts. Cruzan was in an automobile accident in 1983, and suffered anoxia which caused a permanent vegetative state. She is able to breathe without assistance but can only take nourishment through artificial means. While there was still some uncertainty about her prognosis, a gastrostomy tube was inserted to facilitate feeding.

Court Rulings. After it was apparent that Cruzan would never regain consciousness, her parents, who were also her guardians, sought a court order permitting termination of artificial nutrition and hydration (the state hospital where she resided refused to discontinue treatment without a court order). The trial court granted their request, but its order was appealed to the Missouri Supreme Court. That court refused to order termination, stating that Missouri had a strong interest in the preservation of life, and that termination of medical treatment resulting in death would only be allowed

if there was "clear and convincing evidence" that the patient would have wanted treatment discontinued. Before her accident, Cruzan had stated to a roommate and close friend that she would not ever want to live like a vegetable. However, she had never executed a formal declaration to this effect. The Missouri Supreme Court found this evidence was not "clear and convincing." On appeal, the United States Supreme Court affirmed, stating that Missouri's standard was not unconstitutional.

Discussion

Since this is the U.S. Supreme Court's first decision on the refusal of life-sustaining treatment, it is tempting to draw broad conclusions. It is important, however, that this decision not be misinterpreted. It does **not** say that food and water can never be withheld or that family members cannot authorize the removal of life-sustaining treatment from their relatives. All that it says is that a state **can** adopt a requirement that "clear and convincing evidence" of the patient's wishes be shown before terminating treatment to an incompetent patient.

Rights of Competent Patient to Refuse Treatment. The Court, in guarded terms, seemed to recognize the right of a competent person to refuse life-prolonging medical treatment. Most state courts have affirmed this right, and it is appropriate to continue to assume that competent persons may refuse treatment.

Standard of Proof of Wishes of Incompetent Patient. The Court allowed but did not endorse Missouri's strict evidentiary standards. The "clear and convincing" standard applied by the Missouri Supreme Court requires that a person hearing the evidence develop a firm conclusion that a fact has been proven. The highest standard of proof, used primarily in criminal cases, is the "beyond a reasonable doubt" standard. This extremely strict standard is usually not used outside of criminal law. While the court did not find that the clear and convincing standard violated the Constitution, it seemed inclined to accept a variety of different state laws.

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Another state could adopt a "preponderance of the evidence" standard, which merely requires that the evidence lean slightly in favor of one side of the case. A state could require no evidence at all, but defer instead to a surrogate. A state might even assume that patients would not want life-sustaining treatment when permanently unconscious (which public opinion polls would support) and require evidence that they **would** want treatment continued.

Withholding Artificially Administered Food and Water. The Court also assumed, but did not decide, that artificially administered food and water is medical treatment which can be withheld. Therefore, this question is still open; however, because of the many state court decisions so holding and the absence of an Arkansas case to the contrary, it is appropriate to assume that artificially administered food and water is medical treatment, and that it can be withheld in proper circumstances.

Opinion is Limited to Particular Case. As the above discussion shows, this is a very narrow opinion, limited to the facts of this particular case and the laws of the State of Missouri. The primary effect the case has on other cases and other states is that states have been granted broad powers to craft their own laws regarding termination of medical treatment.

Dissenting Opinions. Four justices filed vigorous dissents in this case. These justices believe that Cruzan's constitutional rights have been violated because her own best interests were not sufficiently considered, and because she is being forced to receive medical treatment when there is substantial (if not "clear and convincing") evidence that she would have wanted treatment terminated. The dissenting justices comprise the liberal and aging minority on the court, and, as they retire and are replaced by conservative justices, United States Supreme Court decisions will continue to be conservative, leaving many issues up to state legislatures and courts and refusing to uphold individual rights other than those explicitly stated in the Constitution.

Comment. The two guiding principles of contemporary medical ethics -- patient welfare and patient autonomy -- received little consideration by the Court's majority. The decision was a disappointment to those who hoped the Court would find a fundamental constitutional right to refuse unwanted treatment and then rule that the right could be exercised by family members or other suitable surrogates on behalf of an incompetent patient. The majority did affirm in guarded language a constitutionally protected interest in rejecting such treatment, but they also found that a state could impose substantial barriers to a surrogate's exercise of this right by asserting a compelling interest in the preservation of life, regardless of its quality or meaning to the patient. They did not question the patently false assumptions behind the proclaimed policy of Missouri, that most people would

rather be alive in a persistent vegetative state than be dead, and that few people would want family members to choose for them in such a situation. They allowed Missouri to treat Nancy Cruzan as a symbol, a representative of Life in the abstract, and to discount both her best interests and her own stated wishes.

Comparison Of Arkansas And Missouri Law

Because the *Cruzan* case emphasizes the importance of state laws, we will now turn to the laws which Arkansas has adopted in comparison to those in Missouri. Act 713 of 1987³, the Rights of the Terminally Ill and Permanently Unconscious Act, contains four noteworthy features: (1) it includes the permanently unconscious as well as the terminally ill in its scope; (2) it authorizes two kinds of advance directives--living wills and proxy directives; (3) it appears to allow termination of artificially supplied nutrition and hydration; and (4) it grants family members clear authority to refuse life-sustaining treatment. Let us look at each of these elements in light of *Cruzan*.

Rights of Permanently Unconscious Patients. Advance directive statutes apply in most states only in case of a terminal condition. Missouri requires a prognosis that death will occur in a short time regardless of the application of medical procedures, a very restrictive definition that Nancy Cruzan definitely does not meet.⁴ Arkansas' Act defines a terminal condition more broadly, requiring that death will occur in a short time if life-sustaining treatment is withdrawn. It also includes permanent unconsciousness as a qualifying condition, a condition which she clearly does meet; neither side disputed the fact that she would never regain consciousness. Thus the Missouri advance directive statute did not apply to Nancy Cruzan's case, whereas the Arkansas statute would apply to a similar case in Arkansas.

Living Wills and Proxy Directives. Both Arkansas and Missouri recognize the living will, which contains instructions for future treatment. But Arkansas also recognizes proxy directives, which designate a specific person (usually but not necessarily a family member or friend) to act as a "proxy"⁵ to make health care decisions for incompetent patients. Properly designated proxies are empowered to request, under medically appropriate circumstances, that life-sustaining treatment be withheld. The Supreme Court's decision strongly implied, though it did not explicitly state, that a living will would be the kind of evidence that should meet Missouri's very strict standard of proof. Justice O'Connor's separate concurring opinion was written partly to emphasize her view that a proxy directive should be considered "an equally probative source of evidence." At any rate both kinds of directives are available to Arkansas residents and together constitute perhaps the best assurance that one's treatment wishes will be followed.

Termination of Artificial Nutrition and Hydration. The Arkansas Act also addresses the matter of artificial nutrition and hydration, though not as clearly as one might hope. It appears to sanction withdrawing nutritional support or any other treatment which is not necessary for the patient's "comfort, care or alleviation of pain." Given that the Supreme Court did not draw any distinction between tube feeding and other forms of medical care, and that most state supreme courts have done likewise, it is appropriate to assume that nutrition and hydration can be withdrawn in Arkansas without prior court approval when warranted by the patient's medical condition.

Surrogate Decision-Making. The fundamental issue in the *Cruzan* case was whether or not her family could, in the absence of her own directive, authorize discontinuation of her nutritional support. Missouri's advance directive statute is silent on the matter of surrogate decision-making, and the Missouri Supreme Court chose not to allow the family to refuse death-delaying treatment in the absence of clear and convincing evidence of the patient's wishes. The Arkansas legislature has rejected this approach and, in fact, has specifically authorized family members to make such decisions. A directive to discontinue treatment may be made on behalf of a qualified patient (that is, one who is permanently unconscious or who is terminally ill and no longer competent) by the first available individual in a certain order: guardian, parents of an unmarried minor, spouse, and so on. Thus it is clear that in Arkansas the Cruzans would have been authorized to refuse further treatment on their daughter's behalf.

Conclusion

The *Cruzan* decision does not substantially affect the growing consensus in this country that it is legally, ethically, and clinically correct to forgo life-prolonging treatment in certain cases: when the patient requests it, or when a suitable surrogate requests it on behalf of a patient who is permanently unconscious or terminally ill and incompetent. It does not affect the gathering consensus that nutrition and hydration are medical treatments which can also be withdrawn when not benefitting the patient. We recommend that

Arkansas physicians continue to be guided by the accepted standards of practice unless the courts or legislature of our state adopt new rules or standards. Although advance directives are not necessary to discontinue life-sustaining treatment in Arkansas, they can be very helpful to both physicians and families in making treatment decisions. We recommend that physicians discuss the use of life-prolonging procedures with their patients and document the gist of their conversations, that they encourage their patients to consider advance directives and offer to help execute a document if appropriate, and that they suggest that specific instructions regarding tube feeding be included in the directive. In these ways, tragic cases like that of Nancy Cruzan can best be avoided.

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1. *Cruzan v. Missouri Department of Health*, ___ U.S. ___, 58 L.W. 4916 (1990).
2. *Cruzan v. Harmon*, 760 S.W. 2nd 408 (1988).
3. A.C.A. §20-17-201 et seq. (1989 Supp.).
4. The Missouri court pointed out that Missouri's Living Will legislation did not apply to the *Cruzan* case. 760 S.W. 2nd at 420.
5. The term "proxy" means both the document appointing a decision-maker and the individual appointed.



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Infectious Disease Emergencies in Persons with HIV/AIDS: An Update

Daniel R. Lucey, M.D., M.P.H.*

Catherine R. Lucey, M.D.**

This article discusses four of the most serious opportunistic infections which occur in persons with human immunodeficiency virus (HIV) infection and the acquired immunodeficiency syndrome (AIDS): pneumocystis carinii pneumonia (PCP), cryptococcal meningitis, toxoplasmosis brain abscesses and cytomegalovirus (CMV) retinitis (table 1). Each of these infections classifies an HIV-positive person as having AIDS. These infections generally occur only after the CD4+ T-cell (T-helper) count has fallen from a normal range of over 750 cells/mm³ to less than 200 cells/mm³. Each of these can be successfully treated, but frequently relapse. The probability of relapse is decreased by prophylactic, or suppressive, therapy. Rapid diagnosis and initiation of therapy can significantly impact on the short-term morbidity and mortality due to HIV/AIDS.

Pneumocystis Carinii Pneumonia

Pneumocystis Carinii pneumonia (PCP) occurs at some time in 75% of persons with AIDS in the USA. The clinical presentation, chest X-ray (CXR) appearance, and response to treatment can vary widely (1).

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Opinions expressed herein are those of the authors and do not purport to express views of the Department of the Air Force or any other Department or Agency on the United States government.

Diagnosis

The clinical presentation of PCP can range from a subtle to a fulminant process. Most commonly, patients describe a progressively symptomatic course over 2-6 weeks. This course begins with a non-productive cough and dyspnea on exertion, followed by high fevers and dyspnea at rest. Occasionally, bronchospasm will be a presenting symptom. Purulent sputum is rarely seen with PCP, unless a simultaneous bacterial, mycobacterial or fungal pneumonia is present.

The CD4+ T-cell ("T-helper cell") count can be very useful in deciding how likely the diagnosis of PCP is in an HIV+ person. PCP usually occurs when the CD4+ T-cell count is below 200 cells/mm³ (2). In 1989, the Centers for Disease Control (CDC) recommended that HIV+ persons whose CD4+ T-cells are below 200/mm³, or less than 20% of their total lymphocytes, should be offered prophylactic medication to decrease their risk of PCP.

The CXR in PCP can range from being entirely normal to showing diffuse bilateral infiltrates. Focal infiltrates are occasionally seen. When these appear in the apex of the lung, their appearance can mimic tuberculosis (for which HIV+ persons at all CD4+ T-cell counts are also at increased risk). Apical infiltrates due to PCP may be more common in persons on aerosolized pentamidine for anti-PCP prophylaxis (3). PCP alone does not typically cause hilar adenopathy, cavities or large pleural effusions.

Since the CXR can be normal or show only subtle interstitial changes during early PCP, one should obtain an arterial blood gas (ABG). The ABG will typically show a respiratory alkalosis, hypoxemia and a widened alveolar-arterial oxygen gradient (A-aO₂). The A-aO₂ gradient typically increases with exertion. Similarly, ear oximetry will

reveal oxygen desaturation with exercise.

Other tests which are sometimes helpful in the evaluation of patients for PCP include gallium scans, pulmonary function tests (PFT's) and serum lactate dehydrogenase (LDH) levels. A gallium scan will usually show inflammation of the lung with PCP, even when the CXR is normal. Gallium scans are not specific for PCP, take 48-72 hours to read and may give atypical results of patients has been on prophylactic pentamidine (3). PFT's usually show a decreasing diffusing capacity for carbon monoxide (DLCO) and can show a restrictive pattern, but these abnormalities are not specific for PCP. Finally, an isolated increase in the serum LDH can occur, probably due to lung damage from PCP. Although this finding may suggest PCP, it can occur with other types of pneumonia as well. A markedly elevated LDH is reported to predict a poor prognosis in persons with PCP.

The diagnostic procedure of choice for PCP in an HIV+

can and should be given if the patient is moderately to severely ill, without concern that the *Pneumocystis* organisms will be absent due to therapy. On the other hand, other potential causes of pneumonia which may be sensitive to trimethoprim-sulfamethoxazole could be inhibited, so the index of suspicion or PCP should high if empiric therapy is given prior to bronchoscopy. The number of organisms may be reduced in patients who have been on prophylactic pentamidine. Thus, both transbronchial biopsy and bronchoalveolar lavage may be necessary to diagnose PCP (3) in these patients, although how often this occurs is not yet established.

Treatment

The two first-line drugs for the acute treatment of PCP are trimethoprim-sulfamethoxazole and pentamidine. Tri-

Table 1

Common Infectious Disease Emergencies in Persons with HIV/AIDS: Primary Diagnostic Tests, Acute Treatment, and Prophylactic or Maintenance Therapies

INFECTION	DIAGNOSIS	TREATMENT	PROPHYLAXIS
PCP	Bronchoscopy Induced sputum	Trimethoprim-sulfa Pentamidine (IV)	Pentamidine (aerosol) Trimoprim-sulfa
Toxoplasmosis	CT/MRI Brain biopsy	Pyrimethamine-sulfa Pyrimeth-clindamycin	Pyrimethamine-sulfa Pyrimeth-clindamycin
Cryptococcal Meningitis	CSF/serum antigen CSF culture CSF India ink	Amphotericin B Fluconazole	Fluconazole Amphotericin B
CMV retinitis	Ophthalmologic exam	Ganciclovir	Ganciclovir

person is usually bronchoscopy (4). Bronchoalveolar lavage alone is usually diagnostic. Whether transbronchial biopsy is also performed depends on the individual's presentation and risk of complications such as bleeding and pneumothorax. Whether the patient has been on prophylactic anti-PCP medication may also influence this diagnostic decision. Induced sputum is helpful only in centers with extensive experience with this method of diagnosis and when a negative sputum exam will be rapidly followed by bronchoscopy. Open lung biopsy is almost never needed.

The number of *Pneumocystis* organisms is so high that they are usually still present after a week or more of therapy, at least in patients who have not been on anti-PCP prophylaxis. Thus, empiric treatment while awaiting bronchoscopy

methoprim-sulfamethoxazole is usually begun IV, then switched to an oral formulation of the patient is improving and diarrhea or malabsorption are absent. The dose is 5mg/kg, based on the trimethoprim component, given every 6-8 hours. Pentamidine is give IV as there are no oral form and IM therapy often causes sterile abscesses. The dose is 4mg/kg given once per day. Lower doses are being studied. The duration of therapy for PCP in persons with AIDS in three weeks, regardless of whether one drug is given the entire time or two drugs in succession.

Both drugs commonly cause side effects. The primary side effects of trimethoprim-sulfamethoxazole include leukopenia, thrombocytopenia, rash and hepatitis. The leukopenia may be dose related. The primary side effects of

pentamidine include hypoglycemia, renal insufficiency, hepatitis and hypoglycemia. A 50% dextrose solution should be immediately available for persons receiving pentamidine because the hypoglycemia can be idiosyncratic and life threatening, although rare. Persons on pentamidine who show an acute change in mental status or seizures should be immediately tested and treated for hypoglycemia. Blood glucose levels should be monitored several times per week.

The issue of when to change from one first-line anti-PCP drug to the other due to an apparent lack of clinical response is difficult to resolve. During the initial four days of either therapy, pulmonary function can worsen. The reasons for this deterioration is likely multifactorial, but one hypothesis is that this represents an inflammatory response to the dying *Pneumocystis* organisms. Many clinicians switch from one first-line drug to the other if the clinical status and ABG have not improved by day 5-7 of therapy. Similarly, when to switch drugs due to side effects such as rash, hepatitis or bone marrow suppression with the initial therapy is not clear. These side effects frequently occur during the second week of treatment. Thus, outpatients must still be followed closely during the latter part of their therapy.

Alternative drugs under investigation for the treatment of PCP include dapsone-trimethoprim, trimetrexate, primaquine-clindamycin, BW566 or difluoromethylornithine (DFMO). The role of steroids in the acute management of severe PCP is controversial. Studies on the efficacy of this intervention and on the prevalence of steroid associated side-effects in this clinical setting have yielded conflicting results. One potential rationale for steroid use is to decrease the inflammatory reaction and oxygen desaturation which may occur during the initial four days of anti-PCP treatment. In July, 1990, two authorities from the National Institutes of Health tentatively recommended that corticosteroids be given, along with anti-PCP medications, to patients who present with room air PaO_2 less than approximately 70 mm Hg. The prednisone or prednisolone should be given in a dose between 40 mg every 12 hours to 60 mg every 24 hours (IV or orally) for 5-7 days, then tapered off by day 21 (5). Whether steroids should be started anytime later in the course of PCP, for example with the hope of preventing intubation, is known.

Prophylaxis against PCP should be offered as previously mentioned, or after the patient has completed the three week course of therapy for acute PCP. Either aerosolized monthly pentamidine (300 mg each month using a Respigard II nebulizer) or twice-daily trimethoprim-sulfamethoxazole tablets (one double strength) are recommended. The pentamidine should be diluted in 6 ml sterile water and given 6 liters/minute from a 50-PSI compressed air source (6). Unproven alternatives include dapsone and fansidar. Patients receiving aerosolized pentamidine for PCP prophylaxis may present with atypical CXR patterns (e.g. apical infiltrates, cysts, or cavities) and gallium scan patterns (decreased intensity) if they do develop PCP or extrapulmonary *Pneumocystis* disease (e.g. spleen, skin, bone marrow,

lymph nodes).

Toxoplasmosis Encephalitis

Toxoplasma gondii causes of one of the most common and most treatable opportunistic infections in the central nervous system (CNS) of persons with AIDS. HIV-related immunosuppression allows reactivation of the previously dormant parasite in approximately 10% of persons living with AIDS in this country. It is more common in patients from Europe and developing countries.

Diagnosis

Symptoms of CNS toxoplasmosis are commonly vague and non-specific. Dull headache and subtle changes in mental status are usually present. Focal neurologic symptoms and seizures occurs in approximately 30% of patients and are usually preceded by weeks to months of mild headache. Fever is uncommon.

In the majority of patients, CT scan with contrast will demonstrate multiple ring enhancing lesions. The basal ganglia are often involved. Magnetic resonance image can reveal lesions which are not seen on CT scan. Mild elevation of protein and lymphocyte count may be seen on lumbar puncture (LP); however, the role of an LP is primarily to exclude other infectious causes of CNS dysfunction, such as bacterial or fungal meningitis. In contrast to normal hosts and non-AIDS immunocompromised hosts, persons with HIV disease and reactivation toxoplasmosis rarely show a diagnostic rise in anti-toxoplasma antibodies. Evidence of previous infection (positive IgG titer) is nearly always positive in patient with CNS toxoplasmosis. Thus, a totally absent IgG titer for toxoplasmosis argues against that diagnosis and should lead the clinician to consider alternative diagnoses. These include lymphoma or, less commonly, bacterial, mycobacterial or fungal abscesses.

The definitive diagnostic test for toxoplasmosis is the brain biopsy; however, the use of this invasive tool is controversial. Some clinicians favor use of immediate brain biopsy for all patients with CNS mass lesions in the setting of HIV infection. Realizing that toxoplasmosis is by far the most common cause of treatable CNS mass lesions in this population, some prefer a trial of empiric anti-toxoplasma therapy, reserving brain biopsy for those who fail to respond. A reasonable approach would be to perform prompt brain biopsy in patients with CNS mass lesions and negative IgG titers to *Toxoplasma*, or in those patients with significant intracranial hypertension, for whom a delay in appropriate therapy could be fatal. In persons with AIDS who have positive titers, and whose clinical and radiographic picture is consistent with toxoplasmosis, a two week course of empiric therapy is appropriate. If clinical and CT or MRI improvement occurs by this time, therapy should be continued and no biopsy is necessary.

Treatment

Pyrimethamine (75-100 mg/day after an initial dose of

200 mg) and Sulfadiazine (100 mg/kg/day in 2-4 divided doses) are considered the mainstay of anti-toxoplasma therapy. Most patients show a clinical response within two weeks. A minimum of nine weeks of full dose therapy is recommended, but this must be individualized. Neutropenia is the most common side effect of this regimen and may be alleviated by the use of folic acid (10-50 mg/day). Folic acid should never be used, since it can be utilized by the *Toxoplasma* organisms. Finally, zidovudine (AZT) *in vitro* antagonized pyrimethamine. Whether this occurs *in vivo* is not yet established, so whether zidovudine should be stopped during therapy with pyrimethamine is uncertain at this time.

Clindamycin (900-1200 mg IV Q6^h) in combination with pyrimethamine has been used with some success in sulfadiazine allergic patients (7). It should be noted that many patients with allergies to trimethoprim-/sulfa may still be able to tolerate sulfadiazine. Drugs which may become available for clinical trials include azithromycin, dapsone, trimetrexate, roxithromycin, aprinocid, interferon-gamma and interleukin-2.

Maintenance therapy with pyrimethamine (25mg) and sulfadiazine (2 grams) for 3-5 days per week is recommended to prevent or delay relapse. A lower dose of folic acid (6mg) should be included. Alternative regimens, of uncertain efficacy, include clindamycin-pyrimethamine, sulfamethoxazole-trimethoprim, dapsone, pyrimethamine or clindamycin alone. Periodic CT scans or MRI can be used to follow the response to, and guide dosing of, maintenance therapy.

HIV+ persons who have never been infected by *T. gondii*, as evidenced by negative IgG titers, should be counseled to avoid undercooked or uncooked meats and cat litter boxes in an attempt to prevent acquisition of *Toxoplasma*.

Cryptococcal Meningitis

Like toxoplasmosis and HIV itself, cryptococcal fungal meningitis is a common CNS infectious disease in persons with AIDS in this country. As with PCP and toxoplasmosis, cryptococcal disease probably represents reactivation disease, rather than new exposure to the infectious agent. Cryptococcal meningitis can be the initial, AIDS-defining infection in HIV+ persons.

Diagnosis

Diagnosis of cryptococcal meningitis may be delayed because of its variable presentation. Symptoms may be indolent or acute. Fever and headache occur in over 80% of patients. True meningitis is rare. Only a low-grade fever or subtle cognitive deficits may be present. Focal neurologic symptoms and seizures are less common than with toxoplasmosis or CNS lymphoma. HIV+ persons with any of the above findings, particularly if their CD4+ T-cell count is below 200/mm³, should be suspected of having cryptococcal meningitis.

Exam of cerebrospinal fluid (CSF) is diagnostic. Many clinicians advise a CT scan to rule out mass lesions prior to an LP. CSF cell counts, protein and glucose can all be normal in cryptococcal meningitis due to AIDS. Thus, specific tests for cryptococcal infection must be routinely obtained. The India ink stain reveals the cryptococcal in at least 65% of cases. The fungal cultures are usually positive. The CSF cryptococcal antigen is positive in over 95% of cases and the serum antigen may be even more sensitive (8). Fungal blood cultures should also be obtained.

Numerous LP's are generally not required. Efficacy can be assessed by the clinical response to treatment and the serum cryptococcal antigen titer or fungal blood cultures. Follow up LP's will be needed if the clinical course worsens and to demonstrate eventual (weeks to months) resolution of the positive CSF cultures. In persons with hemophilia, LP's should be performed only after clotting factors specific for their deficiency have been given (e.g. Factor VIII) and a hematologist had been consulted.

Treatment

The two drugs approved for the treatment of cryptococcal meningitis are amphotericin B and fluconazole. Amphotericin B is sometimes combined with flucytosine (5 FC).

Amphotericin B can be given at doses of 0.5-0.8 mg/kg/day for the acute treatment of cryptococcal meningitis. Therapy is continued until a minimum total dose of 15mg/kg (approximately 1 gram) has been given, or longer if necessary to produce negative CSF fungal cultures. Kidney damage due to amphotericin B occurs as a rule and should be anticipated. Providing saline hydration prior to the amphotericin B therapy may decrease the renal toxicity. In addition, amphotericin B commonly causes hypokalemia, hypomagnesemia and bone marrow suppression.

Flucytosine is often not well tolerated by persons with AIDS. If 5-FC is given with amphotericin B, then serum levels should be measured several times per week and must be available in a rapid turn-around time. Potentially fatal side effects of 5-FC include severe bone marrow suppression and hepatitis. The dose of 5-FC should be reduced for renal insufficiency, such as should be expected with concomitant Amphotericin B.

In early 1990, the anti-fungal drug, fluconazole, was approved for the treatment and suppression of cryptococcal meningitis. Fluconazole is available in an oral form which is highly absorbed from the GI tract (9). Thus, the oral and IV dose is the same (400 mg on day one followed by 200 mg/day for 12 weeks after the CSF fungal culture becomes negative). Some clinicians give a higher dose of fluconazole (400 mg/day) until a good clinical and microbiologic response has occurred. On the other hand, some physicians prefer to give amphotericin B for the acute treatment of cryptococcal meningitis and to give fluconazole only afterwards as maintenance, or suppressive, therapy. Others choose to give amphotericin B for the initial 2-4 weeks, or until a good

clinical response has occurred, then switch to fluconazole.

The dose of fluconazole should be reduced for renal insufficiency. A dose of 200-400 mg/day can be given until the creatinine clearance drops below 50 ml/minute. The dose should be decreased to 50% of the recommended dose when the creatinine clearance is between 21-50 ml/minute and to 25% when the creatinine clearance falls to 11-20 ml/minute. One full recommended dose (200-400 mg) should be given after each hemodialysis.

Fluconazole interacts with at least two drugs which HIV+ patients may also be receiving. These drugs are rifampin and diphenylhydantoin (Dilantin). Rifampin increases the metabolism of fluconazole, so a poor clinical response may be due to inadequate fluconazole levels. On the other hand, the interaction between fluconazole and dilantin primarily affects the level of dilantin. Blood levels of dilantin are increased by fluconazole therapy. Thus, dilantin levels should be frequently monitored and the dose adjusted as necessary. Other potential side effects of fluconazole noted to date include hepatitis and rash. To date one case of Stevens-Johnson syndrome has been reported.

After the acute treatment of cryptococcal meningitis, prolonged prophylactic, or suppressive, therapy is recommended to decrease the probability of relapses. On May 1, 1990 in a "Note to Physicians" the Division of AIDS at the National Institute of Allergy and Infectious Diseases cited data showing fluconazole 200 mg/day to be as effective and possibly superior to amphotericin B at 1 mg/kg/week IV. Fluconazole was better tolerated than Amphotericin B in this study. Of note, all patients in this study received amphotericin B as acute therapy for their cryptococcal meningitis.

Cytomegalovirus Retinitis

Cytomegalovirus retinitis occurs late in the spectrum of HIV disease, usually when the CD4+ T-cell count is below 200 cells/mm³. Approximately 15-20% of persons with AIDS develop CMV retinitis. The vasculitis caused by CMV infection can affect all parts of the retina.

Diagnosis

Symptoms are dependent on the retinal area affected, ranging from no symptoms when the infection is peripheral, to rapidly progressive loss of vision when the infection involves the optic nerve or macula. The majority of patients present with complaints of "floaters" or visual field cuts. Fundoscopic exam reveals cotton wool spots and perivascular hemorrhages and inflammation. Unilateral involvement is common. Prompt consultation with an ophthalmologist is essential.

Untreated, retinal lesions of CMV can progress within days to weeks. In the majority of patients, treatment halts the progressive loss of vision due to CMV retinitis. Prompt diagnosis and treatment of AIDS patients with visual complaints is crucial to avoid sudden and total visual loss.

Treatment

Ganciclovir therapy should be started as soon as CMV retinitis is diagnosed. Acute treatment (10-21 days) should be administered IV at a dose of 5 mg/kg twice-a-day. Intravitreal administration of ganciclovir by an ophthalmologist can be attempted if systemic side effects occur which prohibit continued IV use. The majority of patients with CMV retinitis respond to acute therapy with stabilization of their visual acuity. Ganciclovir does not reverse loss of vision induced by CMV (10).

Relapse of CMV retinitis is common. Thus, maintenance therapy with ganciclovir five days/week at 5-6 mg/kg/day is recommended. This maintenance, or suppressive, therapy should begin immediately after acute therapy. As with PCP, toxoplasmosis and cryptococcosis, however, even maintenance therapy will not totally prevent relapse of CMV retinitis in persons with AIDS.

The most serious side effect of ganciclovir treatment is bone marrow suppression. Persons with AIDS frequently already have suppressed bone marrow activity due to their advanced HIV infection and use of the anti-HIV drug, zidovudine (AZT or Retrovir). Thus, patients usually have their zidovudine stopped while on ganciclovir, or at least reduced in dose. Blood counts should be checked several times each week while receiving ganciclovir. If evidence of marrow suppression occurs, then ganciclovir should be reduced in dose, or held altogether, if severe toxicity occurs.

CMV strains resistant to ganciclovir have been reported. Phosphonoformate (Foscarnet) is an alternative anti-CMV drug which may be used in these situations, if it is available. At this time, however, its use is still investigational and its availability is limited in the USA.

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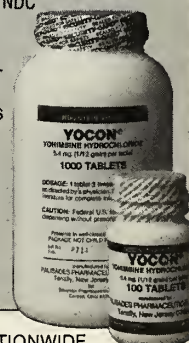
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Other 2

CASES BY RISK GROUP

Homosexual/Bisexual 49

Homosexual & IV Drug User 10

IV Drug User 9

Hemophiliac 1

Transfusion 5

Heterosexual (Contacts) 4

NIR# 4

No identified risk group (NIR)

CASES BY AGE GROUP

Less than 20 5

20 - 29 23

30 - 39 35

40 - 49 16

50 or more 3

OPPORTUNISTIC DISEASE

Pneumocystic Carinii 37

Kaposi's Sarcoma 1

Other Diseases 44

AIDS IN ARKANSAS 1985 - 1990

Total number of cases

reported 335

Number of deaths 211

CASES BY SEX

Male 304

Female 31

CASES BY RACE

White 253

Black 78

Other 4

CASES BY RISK GROUP

Homosexual/Bisexual 213

Homosexual & IV Drug User 38

IV Drug User 37

Hemophiliac 3

Transfusion 17

Heterosexual (Contacts) 17

NIR# 10

No identified risk group (NIR)

CASES BY AGE GROUP

Less than 20 8

20 - 29 105

30 - 39 150

40 - 49 49

50 or more 23

OPPORTUNISTIC DISEASE

Pneumocystic Carinii 158

Kaposi's Sarcoma 12

Other Diseases 165

Source: Arkansas Department of Health.



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2. *Br J Clin Pharmacol* 1985;20: 710-713.
3. Data on file, Lilly Research Laboratories.
4. *Scand J Gastroenterol* 1987;22(suppl 136): 61-70.
5. *Am J Gastroenterol* 1989;84: 769-774.

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Indications and Usage: 1. *Active duodenal ulcer*—for up to eight weeks of treatment. Most patients heal within four weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than one year are not known.

Contraindication: Known hypersensitivity to the drug. Use with caution in patients with hypersensitivity to other H₂-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chloriazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given

an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H₂-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

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Choices of Operative Procedure for Morbid Obesity

Harvey J. Sugerman, M.D.*

David M. Hume, Professor of Surgery*

Morbid obesity has been clearly shown to be associated with many serious medical and psychological problems as well as a significant decrease in life expectancy¹⁻³. Behavioral modification and dietary programs are usually only temporarily successful, as recidivism with weight regain will occur in almost 95% of individuals⁴. Surgery for morbid obesity was initially achieved with the jejunoileal (JI) bypass operation in which 90% of the small intestine was bypassed. This bypassed intestine was then usually drained into the large bowel, usually the transverse colon. Although an effective procedure for weight loss, it was associated with an unacceptable number of complications, some fatal, including cirrhosis, interstitial nephritis, arthritis, recurrent kidney stones, bypass enteritis, electrolyte imbalance, etc.⁵⁻⁷. Most of these complications appeared to be secondary to bacterial overgrowth in the "blind limb" of intestine.

Gastric procedures for morbid obesity were initially proposed 20 years ago and include various types of "gastroplasty," in which the stomach is partitioned into a very small and large pouch connected by a small stoma and the "gastric bypass" (GBP) procedure, in which the stomach is stapled completely shut and a Roux-en-Y limb, or loop of jejunum, is anastomosed to the proximal gastric pouch.

Gastric Bypass vs. Vertical Banded Gastroplasty

Previous studies have found that the gastric bypass was a more effective procedure for weight loss than a gastroplasty⁸⁻¹⁰. This was often attributed to mechanical problems of the gastroplasty procedure, such as stoma or pouch enlargement. More recently, the vertical banded gastroplasty (VBGP) has been proposed, which is characterized by a vertical 50 ml pouch and 1 cm diameter stoma, reinforced with Marlex mesh¹¹. In a randomized prospective trial, we compared the VBGP to a Roux-en-Y gastric bypass¹². Twenty patients underwent each procedure. Randomization was stopped

nine months after the trial was started, when a significantly ($p < 0.05$) better loss of excess weight was noted with GBP than VBGP. When all patients had reached one year since surgery, the difference had become even more significant ($p < 0.01$) with GBP patients having lost $68 \pm 17\%$ of excess weight vs VBGP who lost $43 \pm 17\%$ excess weight¹². The difference was similar at three years, $67 \pm 20\%$ for GBP and $41 \pm 18\%$ for VBGP.

Sweets Eaters vs. Non-Sweets Eaters

It was noted that several patients did extremely well after their VBGP; whereas, the majority did very poorly, having lost very little weight. Upper gastrointestinal radiographic series (UGI) and/or endoscopy revealed that only one VBGP patient had disrupted the staple line. The reason for failure appeared to be the ability of VBGP to tolerate high calorie carbohydrate beverages (Coca-Cola, milk shakes, Kool-aid, etc.) and candy; whereas, GBP patients developed nausea, flushing, lightheadedness, and diarrhea with the ingestion of sweets, i.e., the dumping syndrome. Thus, at one year GBP patients who were identified by our dietitians prior to surgery as being addicted to sweets lost $69 \pm 17\%$ excess weight in contrast to a similar group of sweets eaters who underwent the VBGP who lost $36 \pm 13\%$ ($p < 0.0001$)¹². It has subsequently become our policy to perform VBGP on "gorgers" and GBP on "sweets eaters." Based upon these criteria, approximately 83% of our patients now undergo gastric bypass and 17% VBGP¹³. With selective assignment of patients since 1983, the VBGP patients have lost $53 \pm 19\%$ excess weight at one year, which is significantly ($p < 0.05$) better than randomly assigned VBGP patients and GBP patients continue to lose $68 \pm 20\%$ excess weight¹³.

Proximal vs. Distal Gastric Bypass

We have noted that approximately 12% of our GBP patients fail to lose more than 40% of their excess weight, despite an intact stoma and staple line. These patients were noted by our dietitians to be "junk food nibbleholics," with

* Dr. Sugerman and Mr. Hume are affiliated with the Department of Surgery Medical College of Virginia at Virginia Commonwealth University in Richmond, Virginia.

the frequent ingestion of small amounts of pretzels, potato or corn chips, popcorn, etc. These patients probably need a combined restrictive and malabsorptive procedure. We are currently offering this small subset of patients a "distal gastric bypass," which is a modification of the biliopancreatic bypass procedure developed by Scopinaro in Italy and currently the most popular operation for morbid obesity in Europe ¹⁴. In Scopinaro's procedure, a small stapled gastric pouch is created which is usually larger (200 cc) than the gastric pouch with the standard proximal gastric bypass (50 cc). The small intestine is transected 2.5 meters from the ileocecal valve and anastomosed to the gastric pouch. The bypassed, proximal small intestine is reconnected to the ileum 50 centimeters from the ileocecal valve. In this manner, the amount of food ingested is partially restricted and most of the food that is eaten passes down the small intestine, mostly undigested and unabsorbed, until 50 centimeters from the cecum at which point it meets with bile and pancreatic juice where digestion and absorption occur. In Europe, this procedure is performed with a subtotal distal gastrectomy because of the fear of gastric acid hypersecretion in the bypassed stomach. We have found that acid and gastrin secretion remain quite low, obviating the need for gastrectomy. We have found that the 50 cm common absorption channel is associated with a 79% incidence of protein-caloric malnutrition (albumin <3.0 gm/dl) in patients with a 50 cc gastric pouch and a 33% incidence of protein-caloric malnutrition in patients with a 200 cc gastric pouch ¹⁵. Patients who fail the proximal gastric bypass are currently being offered conversion to a 150 cm common channel distal gastric bypass and we are in the midst of a randomized study in super-obese patients (i.e. >225% IBW) comparing a standard proximal gastric bypass to a distal gastric bypass with a 30 cc gastric pouch and 150 cm absorption channel.

Complications

We have performed more than 450 procedures with an 0.6% early and an 0.6% late mortality. This includes 70 patients with the Pichwickian Syndrome who have undergone surgery with a 1/5% mortality. Most of the late deaths occurred in patients with severe cardiovascular disease. Six of our 58 VBGP patients have developed stomal stenosis. Four of these patients have required conversion to GBP because of the failure of endoscopic dilatation. Five other vbgp have been converted to either proximal or distal GBP, because of inadequate weight loss. Of 202 proximal gastric bypass patients, 13% developed stomal stenosis (all responded to endoscopic dilation) and 11% a marginal ulcer (all but three responded to an H2 blocker). Of greater concern, GBP patients have significantly greater risk of Vitamin B12 deficiency and, in menstruating females, iron deficiency anemia, both of which usually respond to supplemental oral therapy ¹³. The distal gastric bypass should theoretically have all of the proximal GBP risks (i.e. stomal stenosis, marginal ulcer, B12 and iron deficiencies). The

distal GBP will, however, have an additional risk of protein deficiency since there is limited exposure to proteolytic enzymes. This can often be overcome with supplemental oral pancreatic enzymes but may require conversion to a longer, 150 cm absorptive intestinal channel.

Conclusion

In conclusion, several gastric operations have been developed for the treatment of morbid obesity: the vertical banded gastroplasty (VBGP), the proximal gastric bypass (P-GBP) and distal gastric bypass (D-GBP). We have found that these operations should be selectively recommended for patients whose eating patterns are: gorger - VBGP; sweets eater - P-GBP and possibly D-GBD for the super-obese junk food nibbler. These patients are almost invariably thrilled with their loss of appetite following surgery, as well as the disappearance of their addiction to sweets. In our experience, significant weight loss has cured the Pickwickian Syndrome (obstructive sleep apnea, and/or obesity hypoventilation syndrome) ¹⁶, adult onset type II diabetes, hypertension, venous stasis ulcers, stress overflow urinary incontinence, gastroesophageal reflux, pseudotumor cerebri, menstrual irregularity, infertility and hirsutism. It has markedly improved the patients' psychological status, including self-image, acceptance by peers and employability.

The data is overwhelming that morbid obesity is an inherited disease and probably not a result of excessive oral dependency. Nonsurgical treatment will depend on determining the biochemical basis for the problem, with the hope that pharmacological therapy can be developed. The different operative procedures are probably releasing gut hormones that allow the development of satiety or the avoidance of sweets. At this time, surgery is the only proven effective treatment for patients with morbid obesity.

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J. Kelley Avery, M.D.*

Case Study

A 16-year-old male was in a single car, high-speed accident and sustained multiple contusions and fractures, including a fracture of the dorsal spine with significant displacement. Emergency surgery was required to relieve and/or prevent pressure on the spinal cord. A laminectomy was done at T-10 within the first 12 hours of admission and the patient stabilized uneventfully. Within the first 48 hours after his surgery, it was noted that he has some loss of upward gaze on the left. He denied diplopia and visual acuity seemed unaffected; however, on examination, there was some inability of the left eye to move upward with the right eye. The neurosurgeon who had attended the patient initially called in an excellent plastic surgeon with extensive maxillofacial experience for consultation. Additional x-rays of his face revealed a fracture of the floor of the orbit on the left (a blow-out fracture) and in order to relieve what was felt to be some entrapment of the external ocular muscles, surgery was planned. Surgery was carried out uneventfully with the reduction of the fracture of the floor of the left orbit and no apparent difficulties were noted during the operation. However, the patient, upon reacting, complained of loss of vision on the left which never returned.

A lawsuit was filed, charging the plastic reconstructive surgeon with negligence in the performance of the operation, as well as, lack of informed consent. As usual depositions followed with expert witnesses being summoned by both sides. There was found to be absolutely no justification for the charge of negligence related to the surgical procedure. However, numerous expert witnesses were available to testify that failure to inform the patient and/or the parents of this 16-year-old male of the possibility of the loss of vision as a complication of the surgery was a deviation from an acceptable standard. The trial followed and there was a large jury award based solely on the lack of informed consent.


Loss Prevention Comments

More and more suits are being brought and more and more money is being paid out because, after a bad result, the plaintiff patient feels that he or she was poorly informed as to the possible consequences of a surgical procedure. In this case, this young man had excellent care from both his neurosurgeon and from his plastic reconstructive surgeon. The complication that occurred, causing him loss of vision in his left eye, is an extremely serious and regrettable complication; but, nevertheless, it can and does occur in this kind of surgery, even when done by experts in the field.

The question normally is raised, "How much documentation is necessary to avoid this kind of lawsuit?" Our claims attorneys at State Volunteer Mutual Insurance Company say that the cases of this type, where settlements are required or awards are given, are those cases where there is no evidence in the record of any encounter between the patient and the operating surgeon during which there is an attempt to apprise the patient and/or family of the potential risks and benefits of the planned surgery. As was true in this case, the record is simply silent on the entire subject. The surgeon could not specifically remember warning of the possibility of blindness, however unlikely, as a complication of the surgery. Of course, the parents stated that there was no mention of such a complication. It is worth emphasizing that in the experience of SVMIC, we have yet to lose or settle a case on the basis of lack of informed consent in which there is a note by the attending physician to the effect that he/she talked with the patient, discussed the risks, and that the patient seemed to understand the essence of the discussion. It is recommended to include in the discussion the extremely serious complications that can occur, i.e., death, blindness, paralysis, loss of limb, etc., so as provide the patient with all of the knowledge that he or she needs to make an informed decision relation to consenting to allow the surgery to take place.

Patients have been conditioned to expect unrealistically good results from our efforts at treatment. Because of this expectation, when an unexpected or bad result occurs, patients will always feel that they should have known about the possibility of this complication before the fact and, on occasion, this dissatisfaction on the part of a patient will result in the filing of a lawsuit.

* Dr. Avery is the chairman of the Loss Prevention Committee of State Volunteer Mutual Insurance Company and medical director of Ambulatory Services at Saint Thomas Hospital in Nashville, Tennessee.



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Things To Come

October 13

1st Annual Fall Meeting the Southern Association of Geriatric Medicine. Presented by the Southern Medical Association, Birmingham, AL. Meeting will be held in Nashville, TN. CME credit available. For more information, contact LaDonna Nail at 1-800-423-4992.

October 14-17

SMA's 84th Annual Scientific Assembly. Presented by the Southern Medical Association, Birmingham, AL. The Opryland Hotel, Nashville, TN. Hour-for-hour Category I credit available. Fees: \$50.00, SMA members; \$150.00, non-members. For more information, contact Kathy McLendon at 1-800-423-4992.

October 31-November 4

The Office Practice of Primary Care Medicine: Common Problems and Practical Solutions. Sponsored by Sharp Memorial Hospital, San Diego, CA. Le Meridien San Diego, Coronado, CA. Fees: \$360.00, physicians; \$250.00, RN's and Allied Health Professionals. Category I CME credit available. For more information, call (619) 541-4530.

November 1-3

Clinical Allergy for Practicing Physician. Presented by the Washington University School of Medicine, St. Louis, MO. The Ritz-Carlton Hotel, St. Louis. CME Category I credit available. Fee: \$200.00. For more information, contact Cathy Caruso at 1-800-325-9862.

November 8-9

How To Get Started in Medical Practice. Presented by the Southern Medical Association, Birmingham AL. Richmond Marriott, Richmond, VA. CME credit available. For more information, contact LaDonna Nail at 1-800-423-4992.

November 10-11

How To Get Started in Medical Practice. Sheraton Imperial Hotel and Towers, Raleigh, NC.

November 15-16

How To Get Started in Medical Practice. University Inn, Birmingham, AL.

November 17-18

How To Get Started in Medical Practice. Marriott Marquis, Atlanta, GA.

November 15-18

37th Annual Meeting of the Academy of Psychosomatic Medicine. The Pointe at Squaw Peak, Phoenix, AZ. For more information, call (312) 784-2025.

November 25-30

RSNA Scientific Assembly and Annual Meeting. McCormick Place, Chicago, IL. For more information, call Jodi Skrip at (312) 558-1770.

December 3-7

Physicians in Management I. Sponsored by the American College of Physician Executives, Tampa, FL. Hyatt Regency Sarasota, FL. CME credits available. For more information, call, 1-800-562-8088.

December 8

Orthopaedic Update. Presented by the Southern Medical Association, Birmingham, AL. Marriott City Center, Charlotte, NC. CME credits available. For more information, call LaDonna Nail at 1-800-423-4992.

December 8-9

Surviving the 90's. Presented by the Southern Medical Association. Ocean Reef Club, Key Largo, FL. CME credit available. For more information, call LaDonna Nail at 1-800-423-4992.

December 13-14

How To Get Started in Medical Practice. Presented by the Southern Medical Association. Hyatt Regency, Nashville, TN. CME credit available. For more information, call LaDonna Nail at 1-800-423-4992.

December 15-16

How to Get Started in Medical Practice. Ramada Convention Center, Memphis, TN.

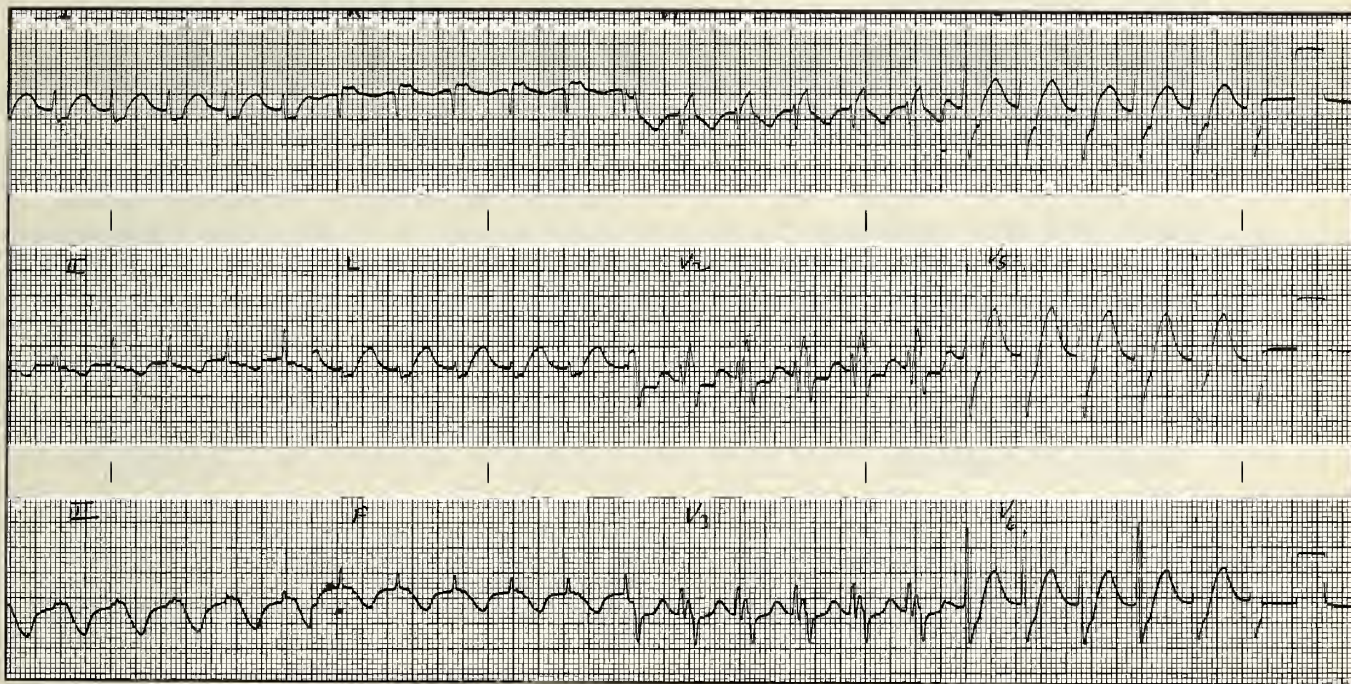
ELECTROCARDIOGRAM of the MONTH



Robert Rook, M.D.
John W. Watson, M.D.

CLINICAL HISTORY:

W.R. is a 50-year-old man with thrombophlebitis who abruptly developed shortness of breath, hemoptysis, and palpitations while on adequate doses of Heparin for his venous disease. A prior electrocardiogram had been normal. What do you think about this trace which was obtained after the new symptomatology developed?



DISCUSSION:

The patient has no P-waves before the QRS complexes. Several leads strongly hint at P-waves following the QRS complexes, especially I, II, aVR, and aVL. Most likely, the patient has junctional tachycardia at rate 140/min. The conduction pattern otherwise is peculiar, bearing resemblance to RBBB. The history given forces one to consider pulmonary embolic events. Electrocardiographic changes of pulmonary embolic events are highly variable, but do include changes of the sort noted here.

The editor wishes to thank Dr. Rook of Conway for his contribution to this month's featured electrocardiogram.

Keeping Up

Sepsis, Newborn

September 19, 12:00 noon. Sponsored by AHEC-Fort Smith and presented by Bonnie Taylor, M.D. Sparks Regional Medical Center, 7th Floor Dining Room. CME Category I credit available.

Interdisciplinary Conference on Access to Health Care and Allocation to Resources in Arkansas in the 1990's

September 20-21, 8:30 a.m. - 5:15 p.m. Sponsored by the UAMS Division of Medical Humanities and the Department of Pediatrics. Sturgis Auditorium, Arkansas Children's Hospital, Little Rock. Fees: \$60.00. CME Category I credit available. For more information, call 686-5622.

Nutrition and Aging VI

September 26-27, 8:00 a.m. Sponsored by UAMS and presented by David Lipschitz, M.D. and Ronni Chernoff, M.D. Excelsior Hotel, Little Rock. Fees: \$150.00; \$60.00, VA employees. CME Category I credit available.

Sports Medicine Update

September 29, times to be announced. Sponsored by UAMS and presented by Brian Hardin, M.D. and Charles Smith, M.D. Arkansas Children's Hospital, Little Rock. Fee: \$45.00. CME Category I credit available.

Anemia in Children

October 16, 12:00 noon. Sponsored by AHEC-Fort Smith and presented by David Becton, M.D. Sparks Regional Medical Center, 7th Floor Dining Room. CME Category I credit available.

Do We Really Need 39 Anti-Hypertensives?

October 17, 12:00 noon. Sponsored by AHEC-Fort Smith and presented by James O. Wells, M.D. Spraks Regional Medical Center, 7th Floor Dining Room. CME Category I credit available.

Loss Prevention Seminar

October 20, 9:00 a.m.-11:00 a.m. and 11:00 a.m.-3:00 p.m. Presented by State Volunteer Mutual Insurance Company and co-sponsored by the Arkansas Medical Society. Fayetteville Hilton. Two Category I credit hours. Free admission. For more information, call 1-800-633-3215 or (615) 377-1999.

1990 Arkansas Physicians Opportunity Fair

October 25, 10:00 a.m. - 3:00 p.m. Presented by UAMS. Jeff Banks Student Union, UAMS campus. For more information, contact Tom South, (501) 686-5813.

ACLS Conference - Pine Bluff AHEC

October 26-28, times to be announced. Sponsored by UAMS and presented by Donald Miller, M.D. Jefferson Regional Medical Center, Pine Bluff. Fees: to be announced. CME Category I credit available.

Annual Primary Care Update 1990

November 2, 7:00 a.m.-5:00 p.m. Presented by Baptist Medical Center's Medical Education Department, Little Rock. J.A. Gilbreath Conference Center, Baptist Medical Center, Little Rock. CME Category I credit available. For more information, call (501) 227-2672.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

Continuing Medical Education Luncheon, second and fourth Friday, 12:30 p.m. AMI Ozark-Quapaw Room. One Category I credit per meeting.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), third Wednesday, 12:30 p.m., Conference Room, Building 1, VAMC

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Faculty Resident Seminar, third Thursday, 12:00 noon, Sturgis Auditorium

Genetics Conference, Wednesdays, 12:00 noon, Sturgis Building, Room 457

Infectious Disease Conference, second Wednesday, 12:00 noon, 2nd Floor Classroom

Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Building, Auditorium

Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., 2nd Floor Classroom

Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, 2nd Classroom

Pediatric Research Conference, first Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

Interdisciplinary AIDS Conference, second Friday, 12:00 noon. LaHarpe Room. Sandwich buffet is served.

Cancer Conference, third Thursday, 12:00 noon, Laboratory Conference Room. Lunch is provided.

Hematology-Oncology Conference, second Thursday, 12:00 noon, Laboratory Conference Room. Lunch is provided.

Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Southwestern Bell/Arkla Room. Refreshments are provided.

Pulmonary Conference, second and fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla Room. Sandwich buffet is served.

Journal Club, every Tuesday, 12:00 noon, Conference Room 1. Lunch is provided.

GYN Surgery Cancer Conference, second Monday, 12:00 noon, AP&L Room. Lunch is provided.

Joint Tumor Conference, first Wednesday, 12:00 noon. CARTI Auditorium. Lunch is provided.

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., Conference Room 1

Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lectures and case presentations. A light lunch is provided.

Pathology Conference, third Tuesday, 3:00 p.m., Pathology Library

Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. A light lunch is provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC Oncology Forum, fourth Thursday, 4:00 p.m., UAMS ACRC 2nd Floor Conference Room, 1.5 credits

Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B

Anesthesia Morbidity and Mortality Conference, second and fourth Tuesdays, 6:45 a.m.; first, third and fifth Thursdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B

CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy

Child Psychiatry Clinical Case Conference/Research Review, most Fridays, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room

Dermatopathology Conference, Tuesdays, 8:00 a.m., UAMS Education Building, Room G/108 A&B

Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Building, Room G/110A&B

Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Building, Room G/110A&B

Emergency Medicine Grand Rounds 1, third Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B

Emergency Medicine Grand Rounds 2, third Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B

GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology Conference Room, #M1/293.

Hematology Fellow's Forum, second, third, and fourth Fridays, 8:15 a.m., ACRC Betsy Blass Conference Room

Hematology/Oncology Clinical Problems Conference, Thursdays, 7:30 p.m., The Terrace Restaurant

Interdisciplinary Gynecologic Cancer Conference, Fridays, 12:30 p.m., UAMS Education Building, Room G106 A&B

Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., St. Vincent Infirmary Education Bldg., Arkla/Bell Room

Little Rock Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC Conference Room three times per month, CARTI Auditorium one time per month

Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Building, Room G/131A&B

Medicine Research Conference, three Wednesdays per month, 4:30 p.m. Shorey Building, Room 3S06

Neurology Clinical Case Conference, Thursdays, 8:00 a.m. VAMC-LR Room 2D109

Neuropathology Conference, Thursdays, 10:00 p.m. UAMS Morgue

Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33

Ob/Gyn Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Building, Room G/131B

Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, Room 3/150, 2 credit hours

Orthopaedic Basic Science Conference, occasional Tuesdays, 11:00 a.m., UAMS Education Bldg., Room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Building, Room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Building, Room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Building, Room B/135
Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Shorey Auditorium
Surgery Basic Sciences Conference, Wednesdays, 4:00 p.m., UAMS Chancellor's Area Conference Room B-2
Surgery Morbidity and Mortality Conference, Wednesdays, 7:00 a.m., UAMS Education Building, Room G/141A
Surgery Staff/Clinical Case Conference, alternating Tuesdays, 7:00 a.m., UAMS Education Building, Room G/141
Surgery Vascular/Radiology Conference, Tuesdays, 5:00 p.m., VAMC-LR Radiology Conference Room
Surgery Vascular Teaching Conference, Thursdays, 3:00 p.m., VAMC-LR Radiology Conference Room.
Urology Basic Sciences Conference, second Wednesday, 5:00 p.m., UAMS Education Building, Room G/106A&B
Urology Clinical Didactic Conference, third Tuesday, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
Urology Core Conference, once or twice monthly, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
Urology Grand Rounds, second and fourth Tuesday, 5:00 p.m., VAMC-LR (4D)
Urology Morbidity and Mortality Conference, last Wednesday, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
Urology Teaching Conference, once or twice monthly, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
Uro-Radiology Workshop (Urologic Imaging), once monthly, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
VA Chest Conference (combined Surgical/Medical Chest Conference), alternating Mondays, 12:15 p.m., VAMC-LR, Room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine Conference Room, Room 1D173
VA Geriatric/Gerontology Research Conference, Wednesdays, 3:15 p.m., VAMC-LR, Room 1E123
VA Hematopathology Conference, Wednesdays, 3:00 p.m., VAMC-LR Pathology Conference Room
VA Lung Cancer Conference (combined Medical/Surgical Lung Cancer Conference), Tuesdays, 3:00 p.m., VAMC-LR, Room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Building 68
VA Medicine-Pathology Conference, Tuesday, 2:00 p.m., VAMC-LR, Room 2D109
VA Medicine Service Resident's Clinical Case Conference, Fridays, 12:00 noon, VAMC-LR, Room 2A109
VA Physical Medicine and Rehab Grand Rounds, fourth Friday, 11:00 a.m., VAMC-NLR Building 68, Room 118 or Arkansas Rehab Institute
VA Psychological Assessment Conference, Tuesdays, 3:00 p.m., VAMC-LR & NLR Psychology Department, 1.5 credit hours
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, Room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine Conference, Thursdays, 8:00 a.m., VAMC-NLR Building 68, Room 118
VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology Conference Room

EL DORADO - AHEC

Behavioral Sciences Conference, first and fourth Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, second Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second and fourth Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, fourth Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, first, second and third Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

Behavioral Sciences Conference, 3rd Wednesday, 12:00 noon, Washington Regional Medical Center
City Hospital Staff Medical Meeting, second Friday, 12:00 noon, Fayetteville City Hospital
Family Medicine Conference, 1st, 3rd, 4th Thursday; 4th Wednesday; 2nd Thursday (odd months) AHEC-NW, 241 W. Spring, Fayetteville
Interesting Case Conference, 1st Friday, 12:00 noon, Fayetteville City Hospital
Medicine Conference, 1st and 3rd Tuesday, 12:00 noon, Washington Regional Medical Center
OB/GYN Conference, October 11, 12:00 noon, AHEC Conference Room
Pediatric Conference, 2nd Wednesday, 12:00 noon, Washington Regional Medical Center
Radiology Conferenc, October 3, 12:00 noon, Washington Regional Medical Center

FORT SMITH - AHEC

Internal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first and third Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.

Chest Conference, second Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided
Craighead/Poinsett Medical Society, first Tuesday, 7:00 p.m. Jonesboro Country Club
Eaker AFB CME Conference, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria
Independence County Medical Society, second Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, fourth and fifth Tuesday, 12:00 noon, St. Bernards Dietary Conference Room. Lunch provided.
Jackson County Medical Society, third Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, third Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, second Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neuroradiology Conference, third Friday, 12:00 noon, St. Bernards Dietary Conference Room. Lunch provided.
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Pocahontas CME Conference, third Wednesday, 12:00 noon and 7:30 p.m., Randolph County Medical Center Boardroom
Tumor Conference, 2nd Thursday, 4th Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided
Walnut Ridge CME Conference, third and last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

PINE BLUFF-AHEC

Behavioral Science Conference, first and third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second and fourth Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, first and fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, second and fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second and fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Cine Radiology, second Friday, 12:00 noon, Wadley Regional Medical Center.
Echo-Cardiology, fourth Friday, 12:00 noon, Wadley Regional Medical Center
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Neuro-Radiology Conference, first and third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

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Medicine in the News

Health Care Access Foundation Update

As of July 1990, the Arkansas Health Care Access Foundation has provided free medical services to 1,597 medically indigent persons.

The program has 1,478 volunteer health care providers including medical doctors, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.

Hansen's Disease Program Develops Nationwide Network

The Regional Hansen's Disease Program provides medical services to Hansen's disease patients throughout the United States. In order to achieve the program's goal of providing care in each patient's community, a nationwide network of over 900 physicians has been developed. Network physicians represent numerous medical specialties, have varied backgrounds, but share a common interest in managing Hansen's disease patients.

There are approximately 6000 patients with Hansen's disease living in the United States today. The Regional Hansen's Disease Program has identified 3,700 of these

patients as currently being under treatment.

Physicians who choose to utilize the program's resources can obtain medications, patient education materials, insensitive limb screening materials and clinical literature at no charge.

Any physician with an interest in managing Hansen's disease patients can be placed on the program's referral list. Interested physicians should contact Mr. Larry Pfeifer, Clinical Coordinator, at 1-800-642-2477.

Just A Reminder: AMA Has Moved

The American Medical Association has moved its headquarters to a new building. The following is their new address and phone number:

American Medical Association
515 North State Street
Chicago, IL 60610
(312) 464-5000

Please correct your records to reflect this change.

AMS Newsmakers

Local volunteers for the American Heart Association, Arkansas Affiliate were honored recently at the Affiliate's 40th Anniversary celebration and annual meeting.

Among the newly elected board members and officers are: **Simmie Armstrong, M.D.**, Pine Bluff; **Robert White, M.D.**, Paragould; **Anthony Fletcher, M.D.**, Little Rock; **Tena Murphy, M.D.**, Little Rock; **Charles Watkins Jr., M.D.**, Little Rock; **Taylor Prewitt, M.D.**, president, and **James Kane, M.D.**, vice president.

Charter Hospital of Little Rock in Maumelle has added **Richard A. Owings, M.D.** and **Lance E. Monroe, M.D.** to their staff.

Dr. Owings is assuming the position of medical director and Dr. Monroe is the director of addiction services. Both are graduates of UAMS and Dr. Monroe is a native of Paragould.

Joe A. Cloud, M.D., of Russellville, was recently inducted as a fellow in the American College of Obstetricians and Gynecologists. The ceremony was held in San

Francisco, CA, as part of the annual convention of the organization.

Dr. Cloud has been associated with the Russellville Women's Clinic since 1986.

Charles E. Crawley, M.D., of Forrest City, is retiring after 44 years in practice. He was honored recently at a reception in which the entire community was invited.

Sam V. Daniel, M.D., a family practitioner in Conway, recently retired from practice after 31 years. Dr. Daniel had served Conway Regional Hospital as chief of staff and was a member of the board of directors.

M.C. Edds, M.D., of Van Buren, is retiring after 38 years of practice. There was a reception recently to honor his many years as a local physician.

E.F. Klein Jr, M.D., has been named as the new chairman of the Department of Anesthesiology in the College of Medicine at the University of Arkansas for

Medical Sciences. Dr. Klein was previously professor and chief of Anesthesia for the Department of Surgery/Anesthesiology at the University of South Carolina School of Medicine in Columbia.

Samuel Koenig, M.D., a Fort Smith family physician and native, has been appointed to the national board of directors of the Commission on Office Laboratory Assessment. Dr. Koenig also chairs the Primary Care Laboratory Practice Committee for the College of American Pathologists.

Samuel Landrum, M.D., of the Holt-Krock Clinic in Fort Smith, was recently elected to the board of trustees of Sparks Regional Medical Center in Fort Smith.

G.E. Malone, M.D., of Atkins, was honored recently by about 200 guests at an open house commemorating his 25 years of service in Atkins.

Weldon T. Rainwater, M.D., a retired Jonesboro pediatrician, has received the Tom T. Ross Award for the Arkansas Public Health Association.

Dr. Rainwater was recognized for his commitment to children and the communities in which he has lived over the past 40 years.

Charles H. Rodgers, M.D., of Little Rock, has been named the Arkansas Academy of Family Physicians 1990-91 Family Doctor of the Year. Dr. Rodgers is alternate delegate to the American Academy of Family Physicians Congress of Delegates from the Arkansas Chapter and served as the Academy's president in 1983-84. He will be the Arkansas Chapter's nominee to the American Academy this fall for the national Family Doctor of the Year award.

Joe H. Stallings Jr., M.D., of Jonesboro, has been installed as president of the Arkansas Academy of Family Physicians at the Academy's 43rd Annual Scientific Assembly held at the Excelsior Hotel and Statehouse Convention Center in Little Rock.

Other officers and directors elected were: **Michael N. Moody, M.D.** of Salem, president-elect; **Richard J. Gardial, M.D.** of Hot Springs, vice president; **James M. Sheppard, M.D.** of El Dorado, treasurer; **Linda Markland, M.D.** of Fayetteville, director; **Ralph Joseph, M.D.** of Little Rock, director; **Sam Koenig, M.D.** of Fort Smith, director; and **Harold Wilson, M.D.** of Monticello, director.

Hunter Steadman, M.D., of Bentonville, has been nominated to the board of trustees of Bats Memorial Hospital. The nomination of his five-year term breaks past tradition in choosing a member of the medical community to become a member with full voting rights.

The Arkansas Academy of Family Physicians has announced the candidacy of **James R. Weber, M.D.** of Jacksonville for the board of directors of the American Academy of Family Physicians. The election will be held during the Academy's Congress of Delegates Session in Dallas, TX, this October.

James Zini, M.D., of Mountain View, has been elected second vice president of the board of trustees of the American Osteopathic Association.

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New Members

BAXTER COUNTY

Ellsworth, Russell W., Urology, Mountain Home. Born March 22, 1945, Detroit, MI. Medical education, University of Michigan, Ann Arbor, 1971. Internship/residency, William Beaumont Hospital, Royal Oak, MI, 1976. Practice experience, 14 years. Board certified.

CRAIGHEAD COUNTY

Cone, John A., Ophthalmology, Jonesboro. Born May 28, 1927, Waresburgh, MO. Medical education, University of Oklahoma, 1964. Internship, Presbyterian Hospital, 1965. Practice experience, 20 years. Board eligible.

INDEPENDENCE COUNTY

Fowler, William G., Psychiatry, Batesville. Born January 26, 1931, Hot Springs. Medical education, UAMS, 1961. Internship, St. Vincent Charity Hospital, Cleveland, OH, 1962. Practice experience, 27 years.

PULASKI COUNTY

Griebel Jr, Jack A., Internal Medicine, Little Rock. Born May 8, 1957, Little Rock. Medical education, UAMS, 1979. Internship, University Hospital, Little Rock, 1986. Residency, Duke University Medical Center, Durham, NC, 1989. Board certified.

Hefley Jr, William F., Orthopedic Surgeon, Little Rock. Born January 10, 1959, Little Rock. Medical education, Vanderbilt University School of Medicine, Nashville, TN, 1985. Internship/residency, UAMS, 1990.

Henson, Gregory N., Internal Medicine, North Little Rock. Born April 6, 1961, Little Rock. Medical education, UAMS, 1987. Internship/residency, University Hospital, Little Rock, 1990. Board eligible.

Johnson, M. Bruce, Gastroenterology, Little Rock. Born November 30, 1959, Memphis, TN. Medical education, University of Tennessee, 1984. Internship/residency, University of Tennessee for Health Sciences, Memphis, 1988. Board certified.

Kleinschmidt, Nancy J., Internal Medicine, Jacksonville. Born December 19, 1958, Fort Smith. Medical education, UAMS, 1986. Internship/residency, University Hospital, 1989. Board certified.

Martin, Robbie L., Nephrology, North Little Rock. Born July 15, 1957, Little Rock. Medical education, UAMS, 1985. Internship/residency, UAMS, 1990. Board certified.

Mellor, Roy D., Anesthesiology, Little Rock. Born October 25, 1957, Phoenix, AZ. Medical education, Brown University Program in Medicine, Providence, RI, 1983. Internship, Carney Hospital, Dorchester, MA, 1984. Residency, Brigham & Women's Hospital, Boston, MA, 1986. Practice experience, 3 years. Board certified.

Moffett Jr, T. Robert, Plastic Surgery, Little Rock. Born January 15, 1957, Houston, TX. Medical education, LSUMC, Shreveport, LA, 1982. Internship, LSUMC, 1987. Residency, University of Louisville, KY, 1989. Board certified.

Robbins, Kenneth V., Radiology, Little Rock. Born August 28, 1956, Searcy. Medical education, UAMS, 1982. Internship/residency, LSUMC, 1984, UAMS, 1989. Board certified.

Schlict, Lisa A., Physical Medicine and Rehabilitation, Little Rock. Born April 7, 1961, Pennsylvania. Medical education, Hahnemann University, Philadelphia, PA, 1986. Internship/residency, Schwab Rehabilitation Center/Mt. Sinai Hospital, Chicago, IL, 1990. Board eligible.

Stanton, T. Michael, General and Vascular Surgery, Little Rock. Born July 16, 1955, Conway. Medical education, UAMS, 1985. Internship/residency, UAMS, 1990.

Warren, G. Emory, Family Practice, Little Rock. Born August 20, 1957, El Dorado. Medical education, UAMS, 1986. Internship/residency, UAMS, 1989. Practice experience, 1 year. Board certified.

Williams, Paul E., Internal Medicine, Little Rock. Born November 15, 1960, Searcy. Medical education, UAMS, 1987. Internship/residency, UAMS, 1990.

Wills, Pamela J., OB/GYN, Little Rock. Born October 7, 1954. Medical education, UAMS, 1986. Internship/residency, UAMS, 1990. Board eligible.

WASHINGTON COUNTY

Holden, Donnie J., Psychiatry, Fayetteville. Born May 14, 1953, Calico Rock. Medical education, University of Juarez, Juarez, Mexico, 1984. Internship/residency, Texas Tech University Health Sciences Center, 1988. Board certified.

RESIDENT

Abbott, Judy A. Born December 16, 1950, El Dorado. Medical education, UAMS, 1990. Internship, AHEC-SW, El Dorado.

Brown, David P. Born May 16, 1953, Victoria, TX. Medical education, Universidad Tecnológica de Santiago, Dominican Republic, 1987. Internship AHEC, El Dorado.

Cook, Joseph A., Family Practice. Born August 31, 1957, Spokane, WA. Medical education, Uniformed Services University, Bethesda, MD, 1987. Residency, AHEC, Pine Bluff.

Gillespie, Elaine B., Family Practice. Born March 11, 1963, Jonesboro. Medical education, UAMS, 1990. Residency, AHEC-NE, Jonesboro.

Jones, Pete, Family Practice. Born September 20, 1950. Medical education, St. Lucia Health Sciences University, 1984.

McKee, Sanders B., Family Practice. Born March 24, 1960, Tampa, FL. Medical education, St. Georges University, Grenada, WI, 1987.

Moran, Kevin M., Orthopaedics. Born August 26, 1960, Los Angeles, CA. Medical education, University of Texas, Houston, 1990. Internship/residency, UAMS.

Pelezo, Anthony J., Emergency Medicine. Born November 28, 1961, Shreveport, LA. Medical education,

University of South Alabama, Mobile, 1990. Internship, UAMS.

Phinney, Dawn L., Pediatrics. Born July 2, 1964, Michigan. Medical education, University of Texas Health Sciences Center, San Antonio, 1990. Residency, UAMS.

Pohle, Floyd G. Born October 18, 1939, Wisconsin. Medical education, University of Autonoma De Guadalajara, Mexico, 1987.

Schonefeld, Michael D. Born November 16, 1963, Corpus Christi, TX. Medical education, LSU School of Medicine, New Orleans, 1990. Internship, UAMS.

Willis, Charlotte R. Born September 3, 1964, Alexandria, LA. Medical education, LSU School of Medicine, Shreveport, 1990. Internship, UAMS.

Winston III, William S. Born April 30, 1959, Memphis, TN. Medical education, Kirksville College of Osteopathic Medicine, Kirksville, MO, 1989.

Wright, James C. Born April 18, 1963, Lake Village. Medical education, Kirksville College of Osteopathic Medicine, Kirksville, MO, 1989.

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In Memoriam

Van C. Binns, M.D.

Van C. Binns, M.D., of Monticello, died Sunday, July 8, 1990. He was 84.

Dr. Binns was a member of the Arkansas Medical Society's 50 Year Club, the American Medical Association and was a Army veteran of World War II.

Surviving is his wife, Evelyn Hogue Binns.

Shirley Ruth Brown

Mrs. Shirley Ruth Brown, of Fort Smith, died Thursday, July 26, 1990. She was 50.

Mrs. Brown was a member of the American, Arkansas, and Sebastian County Medical Society Auxiliaries.

Survivors are her husband, James A. Brown, M.D.; a son, Gregory Brown of Little Rock; a daughter, Sarah E. Brown of Fort Worth, TX; a brother, James Vernor of DeWitt; and three sisters, Peggy Batton of Arcadia, LA, Donna McBroom of DeWitt and Lottie Forrest of West Helena.

Beresford Church, M.D.

Beresford L. Church, M.D., a general physician in North Little Rock, died Tuesday, August 7, 1990. He was 88.

Dr. Church was a member of the American Medical Association, the Arkansas and the Pulaski County Medical Societies.

Survivors are two sons, Beresford L. Church Jr. and Marion Church, M.D., both of North Little Rock, a sister, Mrs. Irene MacLennan of Glendale, CA; five grandchildren, and eight great-grandchildren.

W.H. Lane, M.D.

W.H. "Harold" Lane, M.D., of Dover, died Thursday, July 19, 1990. He was 66.

Dr. Lane was a member of the Arkansas Medical Society, the Dover Chamber of Commerce, and was named Citizen of the Year by the Dover chamber in 1982.

Survivors are two sons, Ron Lane of Elkins Park, PA, and Doug Lane of Russellville; a daughter, Brenda Lane of Dover; a brother, David Lane of Vail, CO; his father and stepmother, Mr. and Mrs. Walter Harold Lane Sr. of Sun City, AZ, and five grandchildren.

James G. Martindale, M.D.

James G. Martindale, M.D., of Hope, died Saturday, July 14, 1990. He was 87.

Dr. Martindale, who practiced medicine for 50 years in Hempstead County, was the last of three generations of Martindale general practitioners and surgeons. He was chief of surgical services at base hospitals in the U.S. and England during World War II.

In 1946, he was awarded lifetime fellowship in the American College of Surgeons. He served as Hempstead County physician, city physician, as chief of staff and other positions at the Hempstead County Memorial Hospital. He was a member of the Arkansas Medical Society and served on several committees.

Survivors are three grandchildren, Betsy Martindale Nettles of Little Rock, Nancy Tollison of Hope and Jud Bush Martindale Jr. of Little Rock; and three great-grandchildren.

Martha Louise Richards

Martha Louise Richards, of Fort Smith, died Friday, July 20, 1990. She was 69.

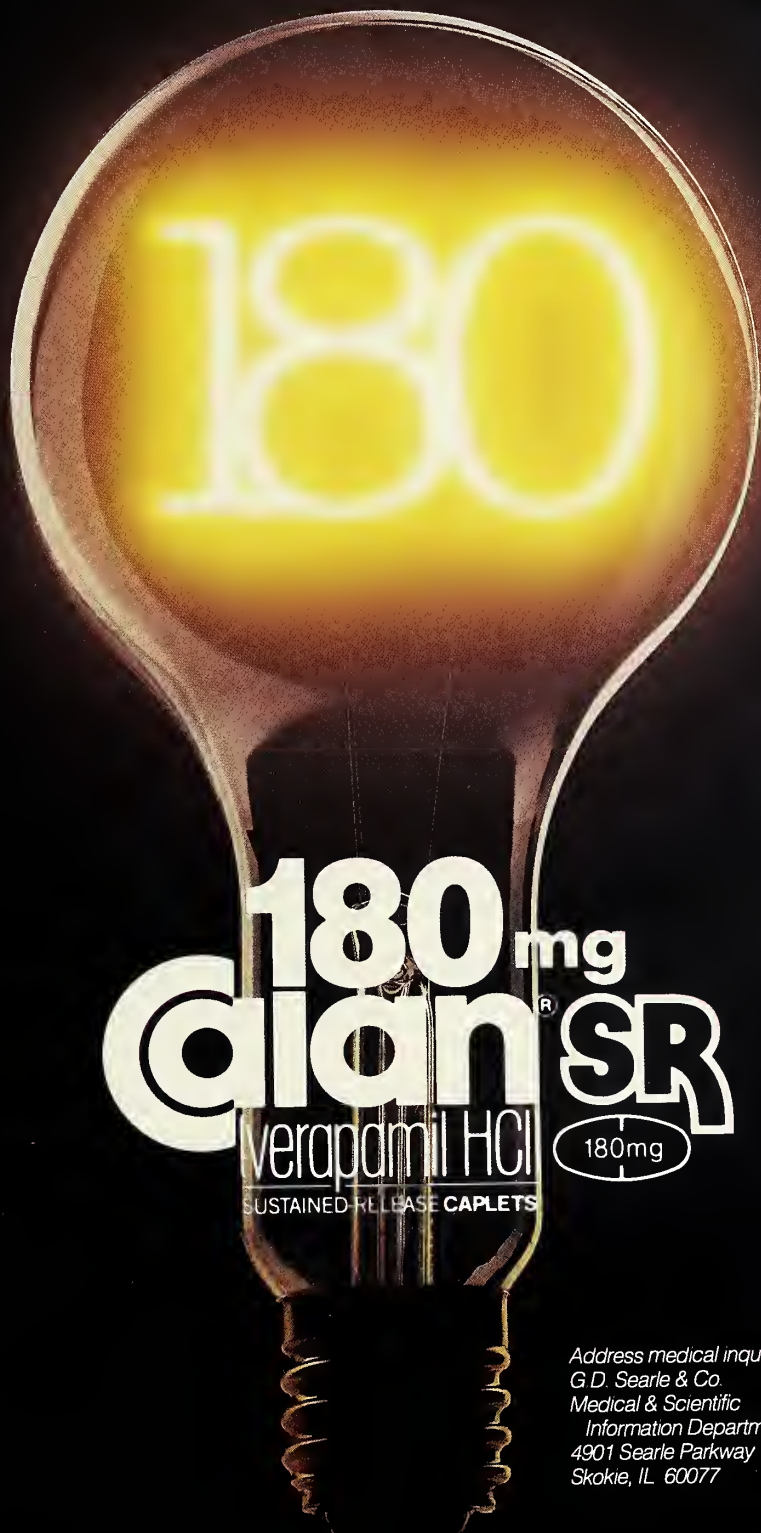
Mrs. Richards was the recipient of the 1990 Shuffield Award presented by the Arkansas Medical Society and the 1990 Arkansas Community Service Award presented by Gov. Bill Clinton. She was honored by both for her work with the AIDS Program of Fort Smith and SCAN.

She was a registered nurse and a volunteer for the American Red Cross Home Nursing Program, the Vietnamese Relocation Project and the Fort Smith Hospice Program. She was a former board member of the American Cancer Society and the American Heart Association, a member of the Multi-State Delta Region AIDS Foundation, the Arkansas AIDS Foundation, and 5th District Registered Nurses Association.

Survivors are her husband, Bill Richards; a son, Steven A. Richards of Booneville; two daughters, Teri Richards Overbay and Margery McClanahan both of Fort Smith; and four grandchildren.

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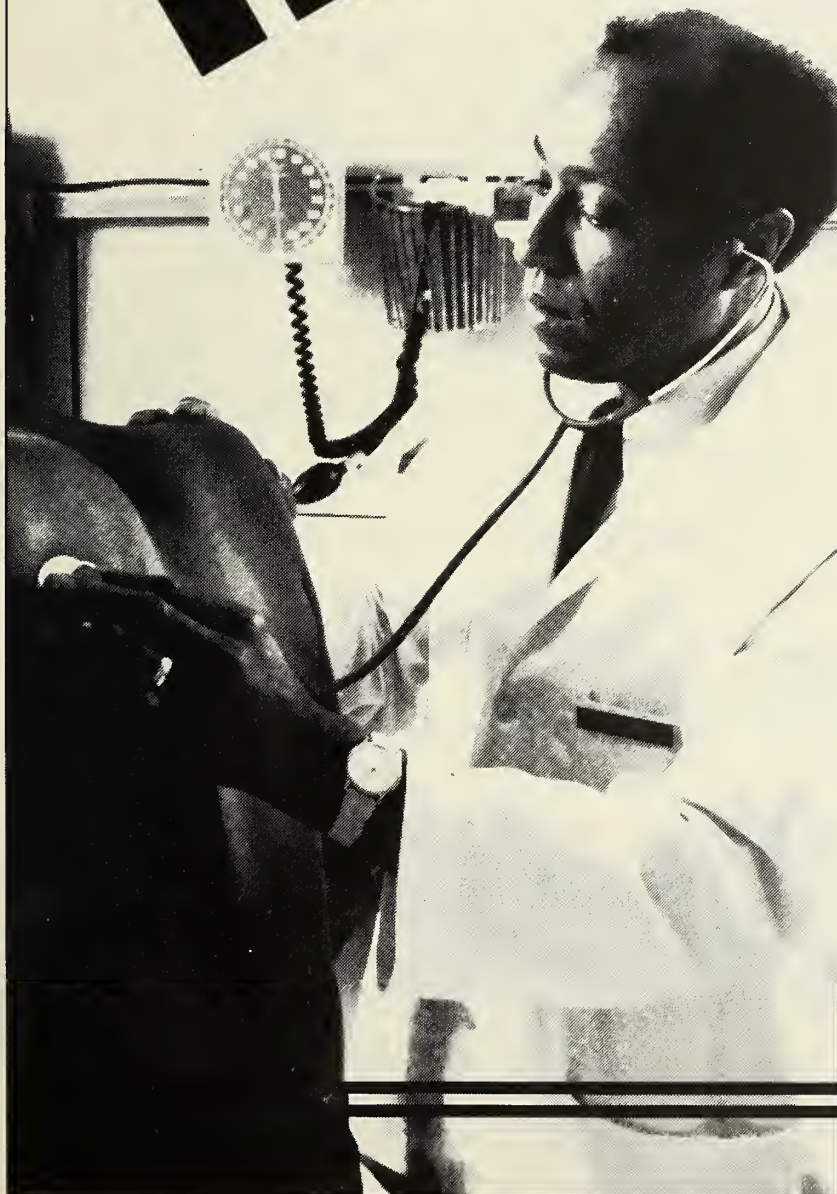


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On our cover: Fall foliage in Arkansas. This photograph was taken by A.C. Haralson and provided by the Arkansas Department of Parks and Tourism. The location is unidentified.

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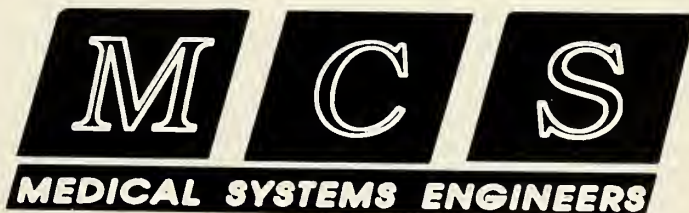
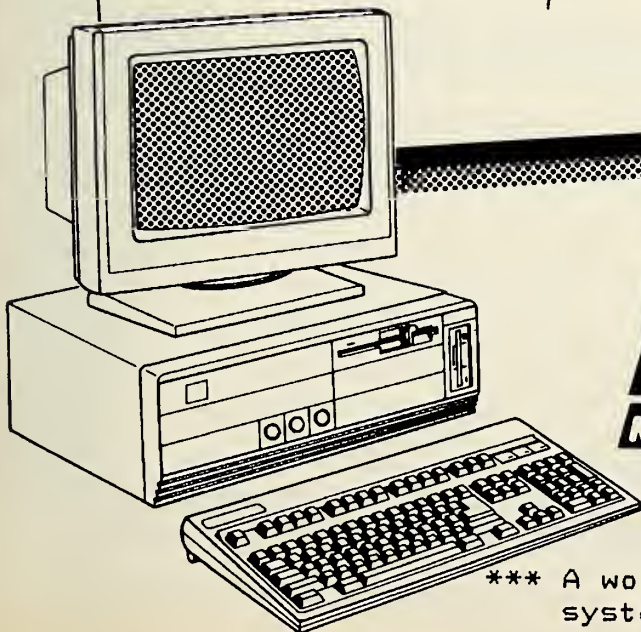
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The Prevention of Death and Serious Injury

Ben N. Saltzman, M.D.*

Do we have our priorities straight? Are we spending our time, expertise, and wherewithal, where the most good can be accomplished for the health of most of our patients?

Last November, at the invitation of the American Academy of Family Physicians, I represented the Arkansas Academy at a continuing education course for Family Physicians in the Orlando, Florida area. The subject was The Prevention of Motor Vehicle Trauma. It was a concentrated one-day course, divided into three sections. The first section dealt with the recognition of motor vehicle trauma as a "leading preventable health problem with significant economic cost to society and its potential for death and injury." The second section discussed the various occupant protection devices and legislation relating to their use. The third section "focused on physician-patient interaction," including the most effective approaches and messages for transmitting occupant information to patients.

I learned that motor vehicle crashes are the leading cause of death for patients between the ages of five and thirty-four. Sixty percent of people killed are under 35 years of age. It is the third leading cause of death for ages 35 to 44 and sixth overall. Twenty percent of all deaths in the 5 to 29 age group are motor vehicle fatalities. Forty percent of all teenage deaths (ages 15 to 19) are motor vehicle related. People aged 15 to 24 are three times as likely to die from motor vehicle trauma than from any other cause. In 1986, more than 3 million people were injured and more than 46,000 people died from this type of trauma. That's one death every eleven minutes.

Death is not the only concern. Five hundred thousand Americans suffer head injuries requiring hospital care each year. More than 50,000 are permanently disabled. Almost half of all head injuries are caused by motor vehicle crashes, resulting in personality changes, dizziness, memory loss, epilepsy, coma, or loss of motor function.

Spinal cord injury is the leading cause of paraplegia and quadriplegia in the U.S. each year; 48 percent caused by motor vehicle crashes. The average age at which this occurs is 30 years old.

Now for the economic impact. In 1986, the total cost to society for motor vehicle crashes was over 74 billion dollars. Health-related costs are exceeded only by cancer.

I learned a great deal about protective devices and about fatal injuries. Fatalities have been recorded at as low as 12 miles per hour. The chances of death or serious injury doubles with every 10 miles per hour, over 50 mph. Being thrown from the vehicle is four times more likely to result in a fatality than if the driver stays in the vehicle.

Safety belts are valuable for the following reasons: The ride down benefit in which the belt begins to stop the occupant before the car comes to a complete stop; the belt keeps the head and face of the occupant from striking the windshield, dashboard, or objects in the car; the belt spreads the stopping force across the strong parts of the body; the belts prevent occupants from colliding with each other; the belt helps the driver to maintain vehicle control, thus decreasing the possibility of an additional collision; and the belt prevents the occupant from being ejected.

There are three types of automatic safety belts: The shoulder belt attached to the door, moves into place when the door is closed; combination shoulder and lap belts attached to the door; shoulder belt attached to a track over the door, moved into place by a small electric motor.

Head restraints should be adjusted, even with the ears, to avoid whip-lash injuries.

Air bags are designed to supplement, not replace, the lap and shoulder belts in the front seat. They are not designed to deploy in roll-overs, rear or side collisions, or in minor events such as panic stops or fender-benders. It is important to wear lap and shoulder belts in cars equipped with air bags. The combination of air bags plus lap and shoulder belts affords the most protection with a 45 to 50% reduction in fatalities and a 50 to 60% reduction in moderate to critical injuries.

* Dr. Saltzman is a family physician with the Pulaski County Health Department in Little Rock, Arkansas.

Beginning this year (1990) all new cars are being equipped with combination lap-shoulder belts in all outboard seating positions, rear as well as front seats.

The observed use of safety belts in the United States has risen in recent years to a high of 46% in 1989. If all front seat occupants wore safety belts, 15,900 lives would have been saved in 1987.

Thirty-six states now have safety belt laws. Arkansas is not one of them. The city of Little Rock does have a seat belt law. Estimates of usage are as high as 70%. This is much better than the national average of cities (50%). All states have mandatory child safety seat laws, but enforcement leaves something to be desired.

The following recommendations are applicable to all physicians in all specialties:

"Specifically, you can help reduce motor vehicle trauma...By protecting yourself and your family with the use of safety belts and child safety seats.

By including questions and discussions about safety belts and child safety seats in the course of your medical practice.

By becoming involved in community efforts to reduce motor vehicle trauma.

By supporting passage and enforcement of safety belt use laws.

By promoting employer policies mandating safety belt use, both at your own place of work and in the community."

"Arkansas Traffic Safety Now" is working toward introducing mandatory seat belt legislation in the next regular session of the legislature. We must work to help enact such legislation. We can save more lives. As a rule, having a seat belt law will influence more people to abide by the law. This is one of the quickest ways of cutting down on immediate death and disability. This would truly be prevention in action.

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Anencephalic Infants As Organ Donors: The Medical, Legal, Moral and Economic Issues

Bonnie J. Taylor, M.D.¹, William M. Chadduck, M.D.^{1,2}, Morris Kletzel, M.D.¹, James E. Rush³, Barbara Moore, and the Bioethics Committee of Arkansas Children's Hospital*

Anencephaly has attracted a considerable amount of recent attention because of the interest in using organs from these infants for transplantation.¹ There are complex medical, legal, and ethical issues raised by this concept which must be dealt with before we can consider anencephalic newborns as potential organ donors, some of which have been discussed recently in the publication of the Medical Task Force on Anencephaly.² Four commonly raised questions are: 1) What is the definition of anencephaly, and is there potential to broaden this definition and include infants with less severe brain malformations? 2) What are the criteria for brain death in the newborn, and should these be applied to infants with anencephaly? 3) If we make the commitment to preserve the organs of an anencephalic infant prior to "death" by aggressive ventilatory support, are we unfairly prolonging the dying process and violating the "human rights" of that infant? 4) What benefit will there be to society if we accept the use of these infants as organ donors and risk "loosening" the moral and ethical principles that protect us as individuals? The purpose of this review is to update the medical community about the status of anencephalic organ donors to underscore the complexity of the issue, and to explain why we believe that transplantation of organs from anencephalic donors cannot be considered for the present.

Description of Anencephaly

Anencephaly is a hopelessly irreparable anomaly signifying absence of the most vital portions of the brain (Fig. 1). The developmental defect also includes absence of the calvarium, the leptomeninges, and the scalp. The appearance of the infant with anencephaly is unique and the diagnosis can be made with virtual certainty when all the

criteria (table 1) are met.

Anencephalic infants may be divided into two groups on the basis of the degree of cranioschisis; merocrania indicates that the cranial defect does not extend to the foramen magnum, and holocrania refers to cases having the cranial defect extending through the foramen magnum and often into the cervical spine. In a series of 41 cases of anencephaly, Vare and Bansal³ found rudimentary cerebral hemispheres in 54%, with complete absence of the cerebral hemispheres in 46%. In 85% of their cases, the cerebellum was absent, and in 75% the brain stem was absent.

Anencephalics of the holocranial type, having absence of both brain and brain stem, would meet the requirements for brain death according to medical criteria and legal requirements. That a spectrum of the deformity occurs is evident in the survival of some anencephalics for days or even weeks. Short-term survivors may fall into the classification of merocranial anencephalics having preservation of some of the brain stem.

Brain Death Determination

Although many anencephalic infants will meet standard criteria for brain death, the diagnosis of brain death can be very difficult in newborn infants as guidelines are specified only for children greater than one week of age. It has been proposed, given the extent of maldevelopment of central nervous system structures, that anencephalic infants can be regarded as "brain absent", therefore eliminating the need to fit into criteria compatible with brain death.⁴ Another proposal is to classify these babies as "dead" because they lack temporal functional integrity.⁵ These proposals were developed to facilitate the possibility of organ transplantation and not on the basis of the anencephalic's best interests and have thus understandably raised many objections among ethicists and theologians.

Because new information is available to strengthen criteria for diagnosis of brain death in newborns, most

* Departments of pediatrics¹ and neurosurgery², University of Arkansas for Medical Sciences and Arkansas Children's Hospital, and the department of philosophy and religion, Philander Smith College³, Little Rock, Arkansas.

physicians and ethicists are unwilling at this time to modify those criteria further in anencephaly. The issue of adhering to brain death criteria becomes important when making a decision about the length of ventilatory support provided to anencephalics to preserve their potential organs for donation until they meet "criteria." The only organized anencephaly donor program in the United States (Loma Linda University) recently abandoned its efforts to harvest organs from anencephalics because of the failure to proclaim brain death in the majority of infants with a seven-day period.⁶

Table 1.
Criteria Which Must Be Met
to Ensure the Diagnosis of Anencephaly

1. A large portion of the skull absent.
2. Scalp, which extends to the margin of the bone, is absent over the skull defect.
3. Hemorrhagic, fibrotic tissue is exposed because of defects in the skull and scalp.
4. Recognizable cerebral hemispheres are absent.

Moral Issues

The moral issues regarding the use of anencephalic infants as potential organ donors can be listed under three categories: 1) The determination of moral status of anencephalic infants, 2) These infants as patients, and 3) Anencephalic infants as property/gifts.

1. Moral Status Determination

At first glance, one would affirm that anencephalic infants do indeed have moral status. But do they? And why is the question of moral status important? The determination of moral status is critical since it determines how a community views individuals. It sets not only an attitude toward individuals but determines what rights and obligations the community has toward the individual and vice versa. How can anencephalic infants claim to have rights and obligations as others do in a human community? Can they make choices, carry out actions, be accountable for behaviors as other members of the human community are accountable? Are anencephalic infants "persons" in the ordinary sense of the word?

Generally, the necessary conditions for being a person implies the capacity for rational, self-conscious life, which requires a more or less intact, functioning central nervous system. What then can we say about the moral status of an anencephalic infant who does not have an intact functioning central nervous system nor will have a future self-conscious

life? We must assume that if moral status is given to anencephalic infants, it is based upon another set of criteria other than that used for "normal" infants. What might this "other" criteria be? We suspect it is based upon the notion of a *prima facie* duty to support life and not death, ie., not to withdraw life support without sufficient justification when there is even a hint of humanity left.

2. The Anencephalic Infant as Patient

When the anencephalic infant is perceived as a patient, he receives beneficence-based obligations of the physician, nurse, and other health-care givers.⁷ In this view anencephalic infants have moral status because they are judged to be critically ill and are at risk to survive. In addition, parents are also under beneficence-based obligations as the moral fiduciaries of their children. In the context of health care, parents are obligated to see to it that their infant's best interests are promoted and protected. In case of the anencephalic infant how can this responsibility be carried out? With the pressure of public policy promoting organ donation and a growing need for infant organs, parents face a moral dilemma. Can offering the infant as a source of organ donation be justified as fulfilling the fiduciary responsibilities of parents? What justification can claim the best interest of the infant will be served by harvesting it's organs for the possible benefit of another?

One could argue that there may be reasonable limits to beneficence-based obligations where the handicap is overwhelming and death is certain. Are the handicaps--no intact functioning central nervous system and certain death--sufficient reason to abridge beneficence--based obligations and to offer the infant as a possible source of organs for donation, either by the parents or the health--care professionals?

3. Anencephalic Infants as Property/Gifts

Because of advances in medical and transplantation technology, serious moral questions have arisen regarding the body and its parts. How ought the body to be used? Who can use it? Can body parts be given as gifts? With these questions being raised, the Uniform Anatomical Gift Act (UAGA) has tried to give the medical community the necessary public policy authority to create a supply of organs to carry out their obligations toward patients who can benefit from transplantation technologies. The moral justification for this Act is based upon the presumption that an autonomous decision has been made by the donor and that this decision is freely given.

Yet serious questions remain unanswered regarding the anencephalic infant. If a decision is made, it is apparently made without regard to the infant's autonomy because it would never have the ability to make a free choice based upon its own goals. We might assert a "reasonable person standard" scenario: if an infant were assumed to be competent to make decisions regarding donation of its organs for the benefit of another (implied autonomy), its reasoned decision would be to donate. We could also counter this

assertion by claiming it is just as reasonable for a competent person to say "no" rather than "yes" to such a request. Evoking the utilitarian concept (greatest good for the greatest number) of social responsibility of persons to be beneficent toward others in need may not give us guidance with regard to the anencephalic infant because it is still forcing an affirmative decision upon a human entity without that entity's permission (paternalism).

Parents of anencephalic infants often regard their infants as "their infant" and property to be held in trust. Parents may have fiduciary responsibilities to promote and protect

society in which many may benefit from research and therapeutic application, but there must be reliable checks against commercialization which would trivialize life or the ghoulish image of "using" people. The lay public also feels strongly that the parents' desires should be respected. When organs can be obtained and maintain respect for the infants, the family may be able to salvage from their tragedy the consolation that their loss can provide life to another child.

Economic Consideration

While the argument that families of these infants should be allowed to donate their infant's organs is a plausible one on the surface, the risks of loosening moral and ethical restrictions as presented above must be outweighed by the actual benefit these organs could potentially provide. There is no question that there is a shortage of children's organs available for transplantation. How much of an impact would harvesting the organs of anencephalic infants actually have on this shortage and what would the economic costs be?

When scrutinizing this we must consider the cost of maintaining anencephalic infants alive while waiting for them to meet the criteria to allow their organs to be harvested. Loma Linda University suspended their program for an indefinite period because of prohibitive costs, inability to proclaim brain death in the majority of patients within a week, and no transplantation of any organs during the program period.⁶ Estimated cost of their program was \$250,000 for each of 12 patients, making it too expensive in terms of cost/benefit. In comparison, Table 2 lists the costs for various established solid organ transplants.⁸

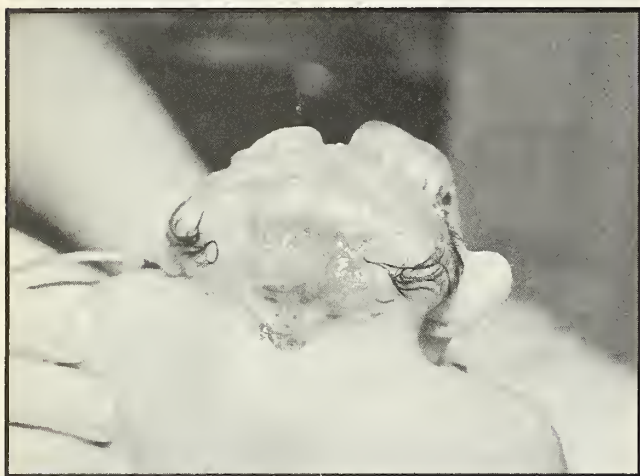


Figure 1

Posterior view of an anencephalic infant illustrating the absence of the calvarium, leptomeninges and scalp.

the well-being of their infant, but this does not imply ownership of the infant's body and its parts. Again, we have a clash of values with regard to the anencephalic infant whose body organs are perceived to be the property of the parents who donate those organs as a gift to benefit others or out of social responsibility.

Lay Public Perception of the Issues

From a lay perspective, the idea of organ donation from anencephalic infants may be considered beneficial because it offers hope for other sick children and comfort to grieving parents. However, any perception of denying "personhood" to the donor should be avoided. Treatment of the anencephalic infant as a dying person should recognize his devastating anatomical and functional deficiency without demeaning his existence.⁴ Care must be taken to avoid additional suffering and pain to the infant and to ensure his dignity in dying. There is the additional problem that under current law the donors may not be legally brain dead. The connotation of "brain absence" may come to have the same medicolegal implications as brain death but should first be recognized by society and confirmed by the courts.⁴

Another important issue is the concept of proportionate good and harm. We have an obligation to pursue issues in our

Table 2
Estimated Costs Associated
with Various Solid Organ Transplants

(From Evan, RW, et al, 1985)⁸

Organ	Estimated Cost (\$)		
	Low	High	Average
Heart	57,000	110,000	95,000
Kidney	25,000	45,000	35,000
Liver	68,000	238,000	130,000
Pancreas	18,000	50,000	35,000

It is also debated whether anencephalic organ donors could supply enough needed organs to justify donor programs. The incidence of anencephaly has been progressively declining since 1970, related to improved prenatal diagnosis of the condition and subsequent pregnancy termination. If the pregnancy is continued, two-thirds of these infants will be stillborn, and of those born alive, 25% will be too small to

be considered as organ donors,⁵ leaving a potential donor base of only 300-400 infants per year in the United States. The hearts of anencephalic infants and fetuses tend to be small, but the rate of cardiovascular malformations is relatively low (ranges from 2-8%),⁹ so many anencephalics could potentially be considered as cardiac donors. The urinary tract is frequently involved by malformations in anencephaly and significant renal anomalies occur in 5-26% of infants.¹⁰ However, success with kidney transplantation from anencephalic donors has been reported. Taking into account that many organs will be unfit for donation from hypoxic damage, malformations or size, only a small percentage of needed organs would actually be provided by anencephalic infants.

Summary Statement

There are no easy answers to the questions raised by the issue of anencephalic organ donors. While the idea of harvesting organs from these infants is a noble concept, it is not yet a mature and viable option considering our current economic, moral, ethical and religious misgivings. While the time has not yet come for full acceptance of an anencephaly donor program, it is an issue worthy of continuing debate, although we must proceed carefully so as not to violate the rights of "humanness" and "personhood" of the anencephalic infant. The end result of this debate may then well be the preservation of life and not its meaningless end.

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in *Rauwolfia Serpentina* (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

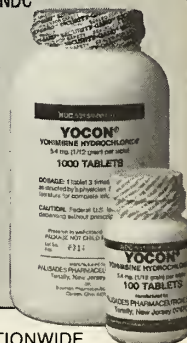
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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M.D. Candidates Discuss Physicians Role in the Political Process

In the 1990 May primary elections, two physicians ran for public office. Little Rock Ophthalmologist Hampton Roy staged a second unsuccessful campaign for Lieutenant Governor and political newcomer, Dr. Vic Snyder, a family practitioner, won Little Rock's District 32 Senate seat by defeating Doug Brandon, a 21-year legislative veteran.

As the November elections near, the Arkansas Medical Society asked these candidates for their candid thoughts on the role that physicians should play in the political process.

A Physicians Political Perspective

by Senator-elect Vic Snyder, M.D., J.D.

The fall campaign season approaches. Just when you thought it was safe to open the mail, requests for donations once again appear. While it is tempting to ignore requests for help from politicians, I encourage you not to do so. We physicians must take an interest in the many races facing Arkansas this fall. For the record: I have no opposition in the fall, and I have no campaign debt. If you send me a check, I'll send it back. But there are many candidates struggling to raise the money and find the volunteers to tell their story.

For a variety of reasons, physicians are generally poor participants in political races. We rarely are candidates, and most of us do not volunteer time to a political race. The irony is that many of the frustrations of a daily medical practice can be solved only by political decision making. Consider this list of current problems facing physicians: poor Medicare reimbursement for primary care; inadequate funding for and physician participation in Medicaid; uninsured children and adults; uncertainty with regard to future governmental involvement in medicine; a high teen pregnancy rate; and great discrepancy in white and black morbidity and mortality rates.

The elections will occur this fall with or without our help. New candidates will take office to lead us toward the twenty-first century. The last decade of the twentieth century must be one of good steady progress for Arkansas in many fields including the area of medical care. Public policy formulation in our fine state would benefit from the participation and unique perspective of physicians.

How and Why You Should Participate in the Political Process

by Hampton Roy, M.D.

As a public spirited citizen, getting involved in the political process will not only allow you to appreciate the issues more, but will help enable you to control your own destiny.

Political candidates develop a close personal relationship with those persons actively involved in their campaigns. This close relationship allows you the opportunity to have input into the political issues affecting medicine and assist the candidates in having a better understanding of the problems facing physicians and their patients.

Too often physicians get wrapped up completely in the world of medicine and are oblivious to the world around them. Political involvement gives you a greater appreciation of all the issues facing you and your patients, stimulates a greater interest in current affairs, and most importantly, presents a positive image of community involvement in the eyes of the public.

At a time when physicians appear to be a popular target for the media and the government, it is important that we become involved in service clubs, in church, and other community activities. This active role in local activities and the political process shows that you are a concerned citizen, that you vote, and enables you to serve as a role model for the community.

My candidacy for Lieutenant Governor provided me tremendous insight into the many little things that doctors can do to get involved in politics. Most can be done after hours and, however small the effort may be, I can assure you that the candidate remembers those that actively worked in the campaign.

Among the activities where physicians and auxiliaries can become involved:

- * Personal financial contributions and assistance in fund raising.
- * Work at the headquarters and at the polls.

- * Send postcards or letters of support to other physicians or friends.
- * Put stickers on cars.
- * Make phone calls.
- * Host party at home.
- * Put sign in yard.
- * Help deliver signs and literature.
- * Address envelopes, stuff and seal campaign literature.
- * Canvas door-to-door handing out literature.
- * Attend rally as representative speaking on behalf of the candidate.
- * Driving people to polls.
- * Promoting the candidate to friends and patients.
- * Being on the kitchen cabinet and adding expertise and help.



How Active Was The Medical Community?

We asked Dr. Roy to briefly recap physician involvement in his campaign. Although his campaign efforts were unsuccessful, there were encouraging signs of increased participation by the medical community.

We had two mailings that went to physicians throughout the state. One had a cover letter written by Dr. Jim Landers and the other by Dr. Jim Weber. We had an additional letter that was sent specifically to ophthalmologists by Dr. Jim Landers. We then had a calling committee of about 30 doctors who called various physicians to get donations. We had a total of 95 doctors, spouses or clinics that gave money to the campaign. This totaled \$18,745.00 for an average amount of \$197.32. I do not have an exact figure of my 1986 campaign, but my general impression is that there was at least twice the participation in this race compared to four years ago. In addition, I got almost \$5,000 from organizations including the Arkansas Hospital Association, the Arkansas Medical Society with in kind contribution, the Arkansas Medical Society State Legislative Fund, the Arkansas Eye PAC and the Craighead/Poinsett Medical Society PAC.

In this campaign, I was pleased with the increased

participation over four years ago when I ran for Lt. Governor. I felt there was more enthusiasm and help from more physicians than there had been previously.

At one point late in the campaign, a rumor came to me that there was a petition that was being circulated among ophthalmologists in the Little Rock area in which a letter was going to be put in the newspaper saying that I was using my political ads to enhance my practice. I could never verify that rumor but there may be some truth to it because I heard it several times. This is of course, ridiculous in that it would be much less expensive for me to advertise through my business and be able to take it off as a business expense, whereas, political expenses are not tax deductible. Secondly, the bulk of the money was put in myself although I was able to get \$77,897.10 donated to the campaign. Approximately 1/3 of this was from medical sources.

One local ophthalmologist called and was very enthusiastic. He said his family worked tirelessly with signs and mailings.

One doctor in the state called me on a regular basis and was able to raise money among his colleagues and his patients. This type of support really helps a candidates through the campaign to win the race.

AIDS IN ARKANSAS 1990

January 1 - December 31, 1990

Total number of cases reported		116	CASES BY AGE GROUP		
Number of deaths		13	Less than 20		5
			20 - 29		32
			30 - 39		53
			40 - 49		21
			50 or more		5
CASES BY SEX					
Male		106			
Female		10			
CASES BY RACE					
White		86	OPPORTUNISTIC DISEASE		
Black		29	Pneumocystic Carinii		52
Other		1	Cryptococcosis		4
			Kaposi's Sarcoma		1
			Candida		20
			HIV Wasting Syndrome		13
			Toxoplasmosis		4
			HIV Encephalopathy		7
			Histoplasmosis		8
			Other Diseases		7
CASES BY RISK GROUP					
Homosexual/Bisexual		71			
Homosexual & IV Drug User		14			
IV Drug User		13			
Hemophiliac		1			
Transfusion		5			
Heterosexual (Contacts)		5			
NIR#		7			

No identified risk group (NIR)

AIDS IN ARKANSAS 1985 - 1990

Total number of cases reported		369	CASES BY AGE GROUP		
Number of deaths		224	Less than 20		8
			20 - 29		114
			30 - 39		168
			40 - 49		54
			50 or more		25
CASES BY SEX					
Male		338	OPPORTUNISTIC DISEASE		
Female		31	Pneumocystic Carinii		173
			Cryptococcosis		19
			Kaposi's Sarcoma		12
			Candida		48
			HIV Wasting Syndrome		30
			Toxoplasmosis		7
			HIV Encephalopathy		23
			Histoplasmosis		24
			Other Diseases		33
CASES BY RACE					
White		278	CASES BY RISK GROUP		
Black		87	Homosexual/Bisexual		235
Other		4	Homosexual & IV Drug User		42
			IV Drug User		41
			Hemophiliac		3
			Transfusion		17
			Heterosexual (Contacts)		18
			NIR#		13

No identified risk group (NIR)

Source: Arkansas Department of Health.

AIDS in Arkansas

AMS Committee on AIDS

Joseph Beck, M.D., Chairman

RAIN in Arkansas

Trudy James*

How shall a physician respond when faced with a patient with end-stage AIDS who is depressed over lack of financial and support resources? What does the doctor tell a 25 year old patient newly diagnosed with the HIV virus who is threatening suicide? How does one respond to an OB/GYN patient of many years who surprisingly tests positive for HIV and becomes depressed, and calls daily because she hasn't anyone else she feels is safe to talk to? What about a single mother from out of town who is becoming ill because she refuses to leave her son, who is hospitalized and terminal with AIDS?

In the Little Rock area of the state, some doctors are finding assistance with such situations from RAIN, the Regional AIDS Interfaith Network.

RAIN is a two-year demonstration grant program funded by the Robert Wood Johnson Foundation. The four-state program was written by an Episcopal laywoman in New Orleans in an effort to make a connection between religious congregations and the AIDS epidemic. The two-fold purpose of RAIN is to bring AIDS education into the churches and synagogues and to develop congregation-based compassionate Care Teams to serve living with AIDS and their loved ones.

Trudy James is the regional coordinator for RAIN in Arkansas; she was hired in September 1989, and provided an office by Christ Episcopal Church. Since that time, Ms. James has made herself and her educational materials available for presentations to religious groups and related organizations of all sizes. Usually she is accompanied by a person living with HIV/AIDS or by a mother who has lost a child to AIDS. She notes that for many in her audiences, this seems to be their first introduction to AIDS education. Many are still fearful of "casual contact infection." Few seem to be aware of the actual risk behaviors, the difference between having the virus and having the disease of AIDS, the impor-

ance of testing, the lengthy incubation period, and the psychosocial losses experienced by those who are infected. Their place of worship seems to be a "safe" place in which to learn about the virus and the disease, to ask their questions and to express their fears.

RAIN uses hand-outs, materials and sermons prepared by the various denominations and encourages religious groups to become part of the education process, which at this time remains our only prevention to the continuing spread of the virus. She reports that she seldom makes a presentation to a religious group without someone approaching her afterwards or calling within a few weeks to share how a friend or family member is living with the disease, or to express fears over past risk behaviors and ask questions about anonymous testing programs.

When adult study groups or Sunday school classes hear from a young person in their 20's or early 30's how they believe they were exposed to the virus when in their teens before they knew anything about AIDS or about safe sex or needle-sharing transmissions, they often inquire about presentations for church youth groups and youth education classes.

In those congregations who wish to become more involved RAIN works with clergy and lay leaders to develop care teams. The teams are recruited in ways that are consistent for each denomination; often surprising themselves with the number of members who volunteer to receive training and assignments.

If seven or more persons sign up, team leaders are selected and a training day is scheduled. Training consists of six to eight hours with a doctor, a nurse, a social worker, an attorney, a pastoral advisor and a panel of persons personally affected by the disease.

Thus far, 11 teams have been trained in Little Rock and two in Hot Spring, representing Episcopal, Methodist, Presbyterian, Jewish, and Interfaith congregations. The 190 care team members have come from all walks of life: business men and women, nurses, doctors, psychiatrists, attorneys, retirees, counselors, housewives, and students. They have

* Ms. James is the regional coordinator for RAIN in Arkansas.

been matched up with 30 different PWA's, nine of whom have died and two have improved and no longer need service.

Referrals have been received from doctors, discharge planners, clinic nurses, and hospital chaplains. RAIN interviews the PWA and/or family members or partner and determines if they need and will accept the service of a team. Client assignments are based on availability and location.

PWA's are often independent, even if needing help, and may be distrustful of "religious people." Team members are fearful about not knowing how to talk to persons who are gay, or former drug abusers. The team frequently begins by meeting simple needs such as transportation to the clinic or grocery shopping to taking in a meal; as they come to know the client and/or other family members, they discover many ways of giving practical support. Team members have offered respite care, laundry and light housekeeping, babysitting, assistance with paperwork, social outings, and most important, friendship.

In Arkansas, our AIDS cases offer a wide variety; teams in Little Rock and Hot Springs have served individuals living alone, heterosexual couples (one with two small children), homosexual couples, young persons living with a parent, two parents, or with another family member. They have included three women and 27 men; five black and 25 white; professionals and persons who were illiterate.

Teams and clients alike seem surprised at how quickly they often become friends; team members frequently report that they feel they are getting more than they are giving. They begin by saying that they are not sure what they can give; many say they cannot stand hospitals, or fear saying the wrong things about death and dying. They have done many tasks never anticipated but sorely needed: sitting in food stamp lines, filling out Medicaid papers, cutting the grass, moving a family to a new apartment, building front steps, restoring phone service, cleaning out dresser drawers, etc. When relationship with a team has been established, clients and their caregivers have seemed to become healthier and enabled to do more for themselves; perhaps a result of some stress reduction.

Doctors and nurses report that teams are available and dependable in times of crisis and extremity. They have driven patients to the emergency room, and to the doctor's office; they visit regularly when a client is in the hospital, relieving family members. In one case, a mother was able to return to work and keep her job because she knew her son would have daily visitors from the care team. Health care professionals have reported shorter hospital stays and patients remaining in their homes longer at the time of death when a care team is active.

When a client dies, team members are there to help with arrangements and memorial service. One team collected funds to help with cremation and burial. Members go through their own grief and loss; many have become very close to their clients. However, even after the sad loss of a special client, several teams have been willing to take on a new assignment as soon as they were needed.

A part of the success of the program is the "team" concept which means that duties are shared among several persons and none suffer burnout. Another component is a monthly team meeting where members decide on their schedule of activities and also take time to process their feelings about their volunteer work. Issues such as homophobia, addictive family systems, grief process, Medicaid cutbacks, fear and stigma they encounter surrounding AIDS--all are discussed. Inservice speakers are sometimes invited to help in understanding difficult issues. There has been little attrition of team members; most report satisfaction in putting their "faith into action." Some call their work "silent evangelism"; they do not preach, but in their caring and affection, the love of God is experienced. Clients and family members say they "never dreamed that religious people could be like this." In some instances, after a care team has been assigned and parents of a client feel their acceptance, they are able to begin sharing the client's illness and their needs with other family members and their own churches and clergy.

Requests are beginning to come to RAIN from congregations throughout the state wanting education programs; and funding is being sought to provide for development of care teams in four more regions of the state experiencing a high incidence of AIDS cases. Calls have been received from persons living with AIDS in smaller towns where isolation and stigma make it difficult for them to access any resources. Congregation-based care teams could fill some of their needs, as well as providing a source of education in a community.

Doctors who would be interested in helping develop care teams in their community or in an education program for their church may call the RAIN office at 375-5908.

Mothers involved in RAIN education programs and mothers of RAIN clients have joined to form a mother's group which meets on the second Friday of each month at Christ Episcopal Church, 509 S. Scott Street, in Little Rock. Several mothers from nearby towns have attended and mothers from throughout the state are welcome, or may call the RAIN office to get a number of another mother to talk with.

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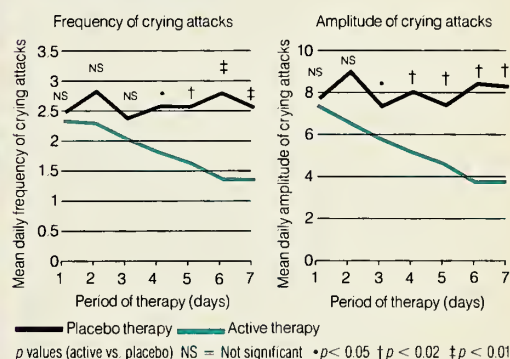
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Arkansas Physicians Care

W. Ray Jouett, M.D.*

The Arkansas Health Care Access Foundation, Inc. (AHCAF), formerly known to you as Arkansas Physician's Care, has just completed its first year. The program's objective, to provide indigent uninsured Arkansans with access to free or reduced cost medical care, is well on its way to being realized.

AHCAF is a non-profit foundation, initiated by the Arkansas Medical Society and funded by a grant from the Arkansas Indigent Care Task Force. Physicians and other health care professionals participate in this volunteer effort by agreeing to donate free or reduced cost medical care to Arkansans who meet the eligibility guidelines.

Nearly 900 Arkansas physicians have agreed to donate medical care, and to date, over 1,500 individuals have received free office visits. This figure does not include the free follow-up visits provided, nor additional free services which were given during the original visit. Many volunteer physicians have also donated their services for hospital inpatient care, including surgery, radiology and other diagnostic testing. Currently, over 9,600 Arkansans are eligible to receive medical services through this referral program.

Other health professional groups contributing to the

success of the program, include the Arkansas Hospital Association, the Arkansas Pharmacists Association, the Arkansas Dental Association, the Arkansas Department of Public Health, the Arkansas Association of Home Health Care Agencies and the Arkansas Department of Human Services. These professionals are donating free or reduced cost care to individuals referred by AHCAF.

With the continued support of the health care professionals who are participating in this program, indigent Arkansans will have access to the medical services that they so desperately need. On behalf of the Arkansas Health Care Access Foundation Board, I would like to thank those individuals who are giving of their time and energy. Your efforts have made Arkansas a front runner in providing innovative health care.

If you would like to become a volunteer in this program, or wish to know more, please complete and return the enrollment card below to AHCAF, P.O. Box 56248, Little Rock, Arkansas 72215, or call 1-800-950-8233.

* Dr. Jouett is chairman of the board of the Arkansas Health Care Access Foundation.

Please enroll me as a volunteer in the Arkansas Health Care Access Foundation, Inc.

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Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of non-susceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions. (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, serum-sickness-like reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055% to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy, occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
- Stevens-Johnson syndrome, toxic epidermal necrolysis,

and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.

- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonía, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

Abnormalities in laboratory results of uncertain etiology

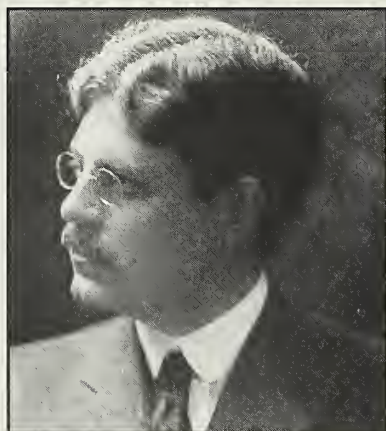
- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
- Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Ceclor and Coumadin concomitantly.
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest[®] tablets but not with Tes-Tape[®] (glucose enzymatic test strip, Lilly).

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Orange King Judd, M.D.

Edwina Walls, M.L.S.*

In 1923, five Little Rock physicians met to form a corporation to construct and operate a private hospital. The hospital formed was Trinity Hospital of Little Rock, one of the earliest HMO's in the United States.

The eldest of the founders of Trinity Hospital was Orange King Judd. He was born to David A. and Annie E. (Ewing) Judd,¹ a farm family of Rantoul, Illinois, on March 21, 1873. He was educated in the public schools of Illinois.² In 1893 he came to Little Rock, and for a number of years, worked as a printer. During his years in medical school, he worked as a Linotype operator for the *Little Rock Gazette*.³ Following his graduation from the University of Arkansas Medical Department in 1905, Judd did postgraduate work at Johns Hopkins in 1906. In 1907 he married Miss Julia A. McMillan.⁴ The couple had no children. From 1907 to 1912, in addition to the private practice of medicine, Judd was the city physician of Little Rock and the superintendent of the Logan H. Roots Hospital.⁵ From 1905 to 1918, he was a faculty member at his alma mater in both the department of medicine⁶ and anatomy.⁷

At Trinity Hospital, Dr. Judd was in charge of the obstetrics and gynecology practice and was one of the general practitioners around which the practice focused. He was an active member of the American, Arkansas, and Pulaski County Medical Societies, except for the years of the Trinity controversy. He served as president of the Pulaski County Medical Society in 1909-1910.⁸ Dr. Judd's early

residence in Little Rock was at the Freiderica Hotel.⁹ He and his family later resided at 307 West Seventeenth. Dr. Judd's death occurred of accidental strangulation at his home on December 28, 1957.¹⁰

In 1988, a relative of Dr. Judd's presented the UAMS Library's Special Collections Division a gold medal which he received from the Arkansas Medical Society in 1905. The medal, bearing the Seal of the Society, was presented to Dr. Judd for "passing the best examination in all branches" of study at the medical department that year.

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* Ms. Walls is the head of the Special Collections department of the University of Arkansas for Medical Sciences, Little Rock, Arkansas.

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REFERRING PHYSICIAN SECONDARY

GROUP NUMBER HICFA

PLACE OF SERVICE CODE

PRIMARY CARRIER

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Resolving Problems in the Physician's Office

David R. Cole*

The Office

It is a popular belief that a malpractice case is won or lost depending on whether the physician handled its complexities correctly and medical standards-of-care were met. In reality, cases often are engendered by or turn on a breakdown in a simple system or procedure. Many times problems go unnoticed because they exist in the physician's "home base"--the office.

A simple mistake, such as a misfiled report, can result in significant loss. For example, a physician may send a patient for a chest x-ray and a report is returned indicating a suspicion of a lung cancer. If that report is filed without being read by the requesting physician, the cancer may go undiagnosed long enough to cause injury to the patient and difficulties for the defense if a suit follows.

Levels of risk may vary from office to office, but there are some common sources of problems which have come to light through review of claim files. A list of these sources and some suggestions for alleviating them follows.

Review of Reports

A simple system, such as instructions to staff that no report is filed unless the physician's initials are on it, would eliminate the problem described above. Some physicians purchase a stamp which marks the report with a block to be initialed by the physician, but there are many methods which might be employed. The key is to ensure that the review procedure is followed consistently by the staff.

Follow-up Systems

Treatment often requires actions outside the immediate treatment encounter. A patient may be sent for an x-ray or

consultation, or specimens may have been sent to outside labs. While certainly the patient bears some responsibility for follow-up of these, some controls are necessary in your office procedure. In one case, a patient was sent for an x-ray. There was no procedure to ensure that the patient got the x-ray or that a report was returned. The physician's follow-up method was to check the record at the patient's next visit. This patient missed his scheduled appointment, and no effort was made to contact him for rescheduling. When the patient was seen a year later, review of the records revealed that the x-ray report indicated a suspicion of cancer. Because the report had not been read by the physician, treatment was delayed a year. This probably could have been avoided by the use of a diary system to ensure pertinent actions are accomplished. The system can be as simple as a notebook or as complex as a program on an office computer. The essential point is that all pertinent actions should be tracked by diary, and that a daily check should be made of all examinations and reports due.

Telephone Management

No office can be managed without a telephone, but often calls are a virtual impediment to the practice. Dealing with calls can lead to problems. Inability to reach the physician by telephone in times of perceived crisis is a common patient complaint. Telephone triage by untrained staff creates a risk that a patient needing emergency care may not be seen on a timely basis. Treatment prescribed over the telephone leaves the physician open to criticism of failure to examine the patient. Also, telephone conversations often go undocumented in the patient's records.

The critical point here is that risk of liability via the telephone can be averted through reviewing telephone procedures. Staff should have a clear understanding of protocols for their own physician's participation in a call. Some physician's use a "call-in hour" during which they are

* Mr. Cole is vice president of Loss Prevention at State Volunteer Mutual Insurance Company, Brentwood, Tennessee.

available to answer calls at designated times. The telephone message pads provided by SVMIC can be used to document calls taken away from the office, and these forms can be filed in the patient's record.

Billing and Collecting

A certain percentage of malpractice suits are in response to bill collection actions. Certainly, no physician should be coerced into waiving a fee by the threat of litigation. However, the physician should review cases before placing them into litigation to collect monies due and see if some arrangements might be made to elicit both the fee due and some goodwill. There have been some cases of medically indefensible treatment that have found their way to court by bill collection.

Answering Services

The most serious threat an answering service presents is failure to pass a message to a physician. Often patients think they are talking to the doctor's office staff when they call; the physician should check to ensure the answering service is disseminating the proper information to patients. Care should be taken to select the most reliable service possible.

Covering Physicians

Lack of information can create real problems for a physician covering for another physician. Often the covering

physician has never seen the patient. Chances are the first communication with the patient is by telephone and the covering physician does not have access to the patient's record. Obviously, provisions cannot be made for every situation, but some contact should be made to apprise the covering physician of potential problem cases. To avoid a break in continuity of patient care, when the other physician returns, a call should be made to the covering physician immediately to discuss potential problems.

Office Staff

Physicians are responsible for the actions of their office staff. Be sure that members of your staff are not exceeding their capabilities and assigned duties. Do not permit your office staff to practice medicine. If possible, develop an office procedures manual with your office staff to ensure that they understand office policy.

Summary

Obviously, physicians prefer to sue their office hours practicing medicine, therefore, they may tend to overlook these administrative functions. In today's busy practice, finding time to review procedures often is difficult. However, an office error becomes wholly the responsibility of the physician when it leads to a misdiagnosis or failure to diagnose. Periodic review of office procedures may help improve patient care and avoid litigation.

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Medical Services Review Committee of the Arkansas Medical Society

Robert B. Benafield, M.D.*

Background

With the implementation of Medicare in July 1966, the Arkansas Medical Society responded to a request by the state's carrier Arkansas Blue Cross and Blue Shield, to establish an advisory committee of practicing physicians to provide professional consultation during the start-up phase. Following implementation, this advisory committee also provided a peer review mechanism for reviewing complex claims. By the late 1960's, it was apparent to both the Society and Arkansas Blue Cross and Blue Shield that there was considerable merit in expanding the scope of review to include private as well as Medicare claims and services. The original name of this advisory group, the 21-Man Committee, was later changed to the Professional Services Review Committee. Then, after Congress enacted the PSRO law, the name was changed to the Medical Services Review Committee (MSRC) and was ably chaired for over 15 years by Dr. Charles F. Wilkins of Russellville.

MSRC Structure and Protocol

The MSRC is comprised of 30 Arkansas physicians appointed by the Council of the Arkansas Medical Society from recommendations of the specialty groups. The members include the executive committee of the Society plus representatives from each major field of practice. The MSRC meets approximately ten times a year at the Blue Cross and Blue Shield offices on the fourth Wednesday of the month. It is the responsibility of the medical director of Arkansas Blue Cross and Blue Shield to develop an agenda along with all pertinent supporting materials to be reviewed (claims, operative notes, x-rays, etc.) All agenda materials are devoid of patient and provider identification. The complete packet of agenda materials is mailed to the MSRC members approximately seven days in advance of the meetings which usually are of two and one-half hours in duration. The case by case recommendations are proposed by majority vote and, for all practical purposes, have been universally accepted through the years for guiding adjudication of claims or developing additional review. If the physician under

review takes exception to the position of the MSRC, he or she is given an opportunity to personally appear before the Committee and present additional information.

1990-91 Medical Services Review Committee

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Thomas H. "Bill" Allen, M.D.	MSRC Vice Chairman
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* Dr. Benafield is medical director at Arkansas Blue Cross and Blue Shield, Little Rock.

The Importance of the MSRC

For well over 20 years, the MSRC has functioned successfully and has contributed immeasurably to the goals of making reasonable reimbursement for effective medical care. The attributes of this form of peer review include:

- * Decision-making by Society appointed practicing physicians
- * Participation by a wide range of specialty representatives
- * Statewide in scope
- * Broad consideration of all available clinical facts and data
- * Reviews are case-specific rather than provider-specific
- * Decisions foster quality care and fairness over punitive measures
- * Procedures for appeal are in place
- * Decisions and guidance are both accepted and fostered by the carrier
- * Awareness and respect for the MSRC not only results in patient advocacy and cost containment, but serves as a sentinel effect for broadly deterring aberrant practice patterns and charges.

On a personal note, as medical director of Arkansas Blue Cross and Blue Shield, I have had the privilege of participating in this unique peer review forum for over 17 years. Through the years I have observed with both pride and gratitude the conscientious, objective and time consuming contributions made by the MSRC membership in search of fair and appropriate decisions. As a result of championing high standards of medical care and fair remuneration for necessary services, the MSRC represents a valuable private sector resource for all concerned.

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The Physician as a Witness

Michael W. Mitchell, J.D.*

- Doctor: Lawyer Jones, I make it a practice not to get involved in my patients' lawsuits.
- Lawyer: Doctor, you have a duty to assist your patient in this case. Besides, if you don't cooperate, I am going to subpoena you to trial with notice, make you sit all day and not pay you anything for your testimony.
- Doctor: You'll find me in surgery that day and not available.
- Lawyer: If you don't appear, I'll have you arrested and sue you for damages.
- Doctor: You can't do that to me! Can you?

Recognizing the physician's disdain for the legal process prompted one appellate court to make the following statement:

We recognize the ongoing tensions between the medical and legal professions in respect to required physician testimony. Doctors generally do not want to come to court, and personal-injury plaintiffs cannot try their cases without them.¹

What are the duties imposed on physicians to testify in cases where their patients are parties? How can those duties be properly carried out in the least disruptive manner?

Ethical Duty to Testify

The American Medical Association states the physi-

cian's ethical obligation to his patient to render legal assistance as follows:

...the physician has an ethical obligation to assist in the administration of justice. If a patient who has a legal claim requests his physician's assistance, the physician should furnish medical evidence, with the patient's consent, in order to secure the patient's legal rights.²

Legal Duty to Testify

Most jurisdictions recognize the general duty of a physician to provide medical evidence on behalf of the patient. One court in dictum stated the duty as follows:

Part of a doctor's duty of total care requires him to offer his medical testimony on behalf of the patient if the patient becomes involved in litigation over injury or illness which the doctor treated...³

Most jurisdictions provide that a treating physician has no duty to appear and testify at trial when the physician has not been served with a subpoena.⁴ However, in 1988 a New Jersey jury held a physician liable to his patient for over \$100,000 for failing to appear and testify even without a subpoena.⁵ In *Spaulding v. Hussain*, supra, the patient was injured in a fall at a junkyard. Shortly after the injury, the plaintiff began to see Dr. Hussain for treatment of his injuries. The physician-patient relationship continued for over two years. Eventually, the patient brought a negligence suit against the owner of the junkyard. Dr. Hussain agreed to testify about the seriousness of the plaintiff's injuries. However, once the trial date was set, Dr. Hussain advised the plaintiff's attorney that he would be out of the country and unable to

* Mr. Mitchell is the general counsel for the Arkansas Medical Society and is a partner in the Mitchell & Roachelle Law Firm in Little Rock, AR.

attend. The trial was rescheduled for one month later. Several times were set during the trial for Dr. Hussain to testify, but he never appeared. Without Dr. Hussain's expert testimony concerning the plaintiff's injuries, the plaintiff was forced to settle the case for an inadequate amount. Subsequently, the plaintiff sued Dr. Hussain for breach of his fiduciary duty and claimed this breach constituted professional malpractice. The jury returned a verdict against the doctor. The court gave the following jury instruction:

A doctor, I charge you, has the duty, when he undertakes to treat a patient, to treat the whole patient...When a doctor treats an accident victim, the physician impliedly agrees to appear and testify on behalf of his patient on issues such as the nature, extent and casualty of his patient's injuries.⁶

Even though Dr. Hussain was not subpoenaed, he promised on numerous occasions to appear and testify. Had he not agreed to appear, a subpoena would likely have been required to subject him to liability. The appellate court agreed that a treating physician had a duty to render litigation assistance to his patient. However, the court said that assistance might not require him to attend trial, but he would still be required to render some "litigation assistance, including the rendering of reports, consultation with counsel and forensic witnesses, and the like."⁷ Furthermore, the court went on to say that the physician could fulfill his duty to render litigation assistance usually by submitting a videotaped deposition.

Subpoena to Testify at Trial

In Arkansas, rules governing the subpoena process are promulgated by the Arkansas Supreme Court on recommendation by a committee of lawyers appointed by the Court.⁸ A subpoena is a legal process requiring a witness to appear and give testimony and may require the witness to bring certain specified documents.⁹ A subpoena is issued by the clerk of the court in which the witness is to appear and is usually served by the sheriff's office, but may be served by anyone not a party who is 18 years of age or older.¹⁰ A subpoena may be delivered in person or by the sheriff via telephone.¹¹ A subpoena may also be served by an attorney in the case by certified mail return receipt requested.¹²

A witness may be required to attend anywhere in the State of Arkansas when the subpoena is properly served at least two days prior to trial not counting the day of service or in a shorter time if ordered by the court.¹³ A subpoena must be accompanied by a witness fee of \$30 per day and 25 cents per mile for travel.¹⁴ If service is by telephone, the witness fee must be tendered prior to or at the time of the appearance.¹⁵ If the trial is continued, the subpoena remains in effect so long as the witness has notice of the new time for trial.¹⁶ Any person subpoenaed must remain in attendance at the trial to give testimony unless excused by the party issuing the subpoena or by the court.¹⁷

Subpoena for Deposition

The provisions for witness fee, travel fee and service are the same from deposition as for trial with three exceptions. First, the witness must be served at least five days prior to the deposition.¹⁸ Second, the witness cannot be required to attend further than 100 miles for the witness' residence or place of employment.¹⁹ Third, "the court shall require the party seeking discovery to pay the expert a reasonable fee..."(emphasis added)²⁰

Sanctions for Failure to Obey Subpoena

When a witness fails to obey a subpoena or intentionally evades service of a subpoena, the witness is subject to arrest to be brought before the court to give testimony and to answer for contempt.²¹

Conclusion

There is little dispute that a physician has a legal and ethical duty to provide litigation assistance to the patient. A physician can be commanded by subpoena to attend a deposition, although the practice in Arkansas is to schedule depositions at the convenience of the physician. The physician can also be commanded by subpoena to attend at trial. In practice, the attorney usually notifies the physician weeks in advance and later has a subpoena issued. Although the rules do not provide for a "reasonable fee" for trial testimony as they do for deposition, the physician, nevertheless, should request an agreement with the attorney for payment of a reasonable fee. If the attorney agrees, a fee statement should be directed to the attorney and not the patient. It is rare, though not unheard of, for a lawyer to resort to forcing a physician to testify at trial pursuant to subpoena without reasonable compensation. It appears advantageous to the physician in terms of convenience of place, time and considerations of reasonable fee to provide litigation assistance through a deposition.

The American Bar Association and the American Medical Association adopted in 1955 and revised in 1981 a professional code for interprofessional relationship between physicians and attorneys.²² If the Code is followed by both doctors and lawyers, it appears that both professions will be treated properly and may carry out their obligations with the least amount of interference. Hopefully, more aspects of the Code can be installed in the Arkansas Rules of Civil Procedure. The Code, quoted in total, concludes this article.

National Interprofessional Code for Physicians and Attorneys

Preamble

The provisions of this Code are intended as guides for physicians and attorneys in their inter-related practice in the areas covered by its provisions. They are not laws, but suggested rules of conduct for members of the two profes-

sions, subject to the principles of medical and legal ethics and the rules of law prescribed for their individual conduct.

This Code constitutes the recognition that, with the growing interrelationship of medicine and law, it is inevitable that physicians and attorneys will be drawn into steadily increasing association. It will serve its purpose if it promotes the public welfare, improves the practical working relationships of the two professions, and facilitates the administration of justice.

Medical Reports

The physicians upon proper authorization should promptly furnish the attorney with a complete medical report and should realize that delays in providing medical information may prejudice the opportunity of the patient either to settle his claim or suit, delay the trial of a case or cause additional expense or the loss of important testimony.

The attorney should give the physician reasonable notice of the need for a report and clearly specify the medical information which he seeks.

It is improper for the attorney to abuse a medical witness or to seek to influence his medical opinion. Established rules of evidence afford ample opportunity to test the qualifications, competence and credibility of a medical witness; and it is always improper and unnecessary for the attorney to embarrass or harass the physician.

Fees for Services of Physicians Relative to Litigation

The physician is entitled to reasonable compensation for time spent in conference, preparation of medical reports and for court or other appearances. These are proper and necessary items of expense in litigation involving medical questions. The amount of the physician's fee should never be contingent upon the outcome of the case or the amount of damages awarded.

Payment of Medical Fees

The attorney should do everything possible to assure payment for services rendered by the physician for himself or his client. When the physician has not been fully paid, the attorney should request permission of the patient to pay the physician from any recovery which the attorney may receive on behalf of the patient.

Implementation of this Code at State and Local Levels

In the event similar action has not already been taken, this Code should, in the public interest, be appropriately implemented at state and local levels for the purpose of

improving the interprofessional relationship between the legal and medical professions.

Consideration and Disposition of Complaints

The public airing of any complaint or criticism by a member of one profession against the other profession or any of its members is to be deplored. Such complaints or criticism, including complaints of the violation of the principles of this Code, should be referred by the complaining doctor or lawyer through his own association to the appropriate association of the other profession; and all such complaints or criticism should be promptly and adequately processed by the association receiving them.

Conferences

It is the duty of each profession to present fairly and adequately the medical information involved in the legal controversies. To that end the practice of discussion in advance of the trial between the physician and the attorney is encouraged and recommended. Such discussion should be had in all instances unless it is mutually agreed that it is unnecessary.

Conferences should be held at a time and place mutually convenient to the parties. The attorney and the physician should fully discuss the medical information involved in the controversy.

Subpoena for Medical Witness

Because of conditions in a particular case or jurisdiction or because of the necessity for protecting himself or his client, the attorney is sometimes required to subpoena the physician as a witness. Although the physician should not take offense at being subpoenaed, the attorney should not cause the subpoena to be issued without prior notification to the physician. The duty of the physician is the same as that of any other person to respond to judicial process.

Arrangement for Court Appearances

While it is recognized that the conduct of the business of the courts cannot depend upon the convenience of litigants, lawyers or witnesses, arrangements can and should be made for the attendance of the physician as a witness which take into consideration the professional demand upon his time. Such arrangements contemplate reasonable notice to the physician of the intention to call him as a witness and to advise him by telephone, after the trial has commenced, of the approximate time of his required attendance. The attorney should make every effort to conserve the time of the physician.

Physician Called as a Witness

The attorney and the physician should treat one another with dignity and respect in the courtroom. The physician should testify solely as to the medical facts in the case and should frankly state his medical opinion. He should never be an advocate and should realize that his testimony is intended to enlighten rather than to impress or prejudice the court or the jury.

Special thanks to Stephanie M. Bartels for her contribution to this article.

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October 14-17

SMA's 84th Annual Scientific Assembly. Presented by the Southern Medical Association, Birmingham, AL. The Opryland Hotel, Nashville, TN. Hour-for-hour Category I credit available. Fees: \$50.00, SMA members; \$150.00, non-members. For more information, contact Kathy McLendon at 1-800-423-4992.

October 31-November 4

The Office Practice of Primary Care Medicine: Common Problems and Practical Solutions. Sponsored by Sharp Memorial Hospital, San Diego, CA. Le Meridien San Diego, Coronado, CA. Fees: \$360.00, physicians; \$250.00, RN's and Allied Health Professionals. Category I CME credit available. For more information, call (619) 541-4530.

November 1-3

Clinical Allergy for Practicing Physician. Presented by the Washington University School of Medicine, St. Louis, MO. The Ritz-Carlton Hotel, St. Louis. CME Category I credit available. Fee: \$200.00. For more information, contact Cathy Caruso at 1-800-325-9862.

November 8-9

How To Get Started in Medical Practice. Presented by the Southern Medical Association, Birmingham AL. Richmond Marriott, Richmond, VA. CME credit available. For more information, contact LaDonna Nail at 1-800-423-4992.

November 10-11

How To Get Started in Medical Practice. Sheraton Imperial Hotel and Towers, Raleigh, NC.

November 15-16

How To Get Started in Medical Practice. University Inn, Birmingham, AL.

November 17-18

How To Get Started in Medical Practice. Marriott Marquis, Atlanta, GA.

November 11-14

Arthroscopy Association of North American Fall Course. Westin LaPaloma Hotel, Tucson, AZ. Category I credit available. For more information, call (708) 299-9444.

November 15-18

37th Annual Meeting of the Academy of Psychosomatic Medicine. The Pointe at Squaw Peak, Phoenix, AZ. For more information, call (312) 784-2025.

November 25-30

RSNA Scientific Assembly and Annual Meeting. McCormick Place, Chicago, IL. For more information, call Jodi Skrip at (312) 558-1770.

December 3-7

Physicians in Management I. Sponsored by the American College of Physician Executives, Tampa, FL. Hyatt Regency Sarasota, FL. CME credits available. For more information, call, 1-800-562-8088.

December 8

Orthopaedic Update. Presented by the Southern Medical Association, Birmingham, AL. Marriott City Center, Charlotte, NC. CME credits available. For more information, call LaDonna Nail at 1-800-423-4992.

December 8-9

Surviving the 90's. Presented by the Southern Medical Association. Ocean Reef Club, Key Largo, FL. CME credit available. For more information, call LaDonna Nail at 1-800-423-4992.

December 13-14

How To Get Started in Medical Practice. Presented by the Southern Medical Association. Hyatt Regency, Nashville, TN. CME credit available. For more information, call LaDonna Nail at 1-800-423-4992.

December 15-16

How to Get Started in Medical Practice. Ramada Convention Center, Memphis, TN.

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Please see next page of this advertisement for references and a brief summary of prescribing information.

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References:

1. Data on file, G.D. Searle & Co.
2. 1988 Joint National Committee: The 1988 report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med* 1988;148:1023-1038.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control mild heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol clearance may occur with combined use. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration.

Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, increased urination, spotty menstruation, impotence.

12/21/89 • P90-W198V

SEARLE

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Address medical inquiries to:
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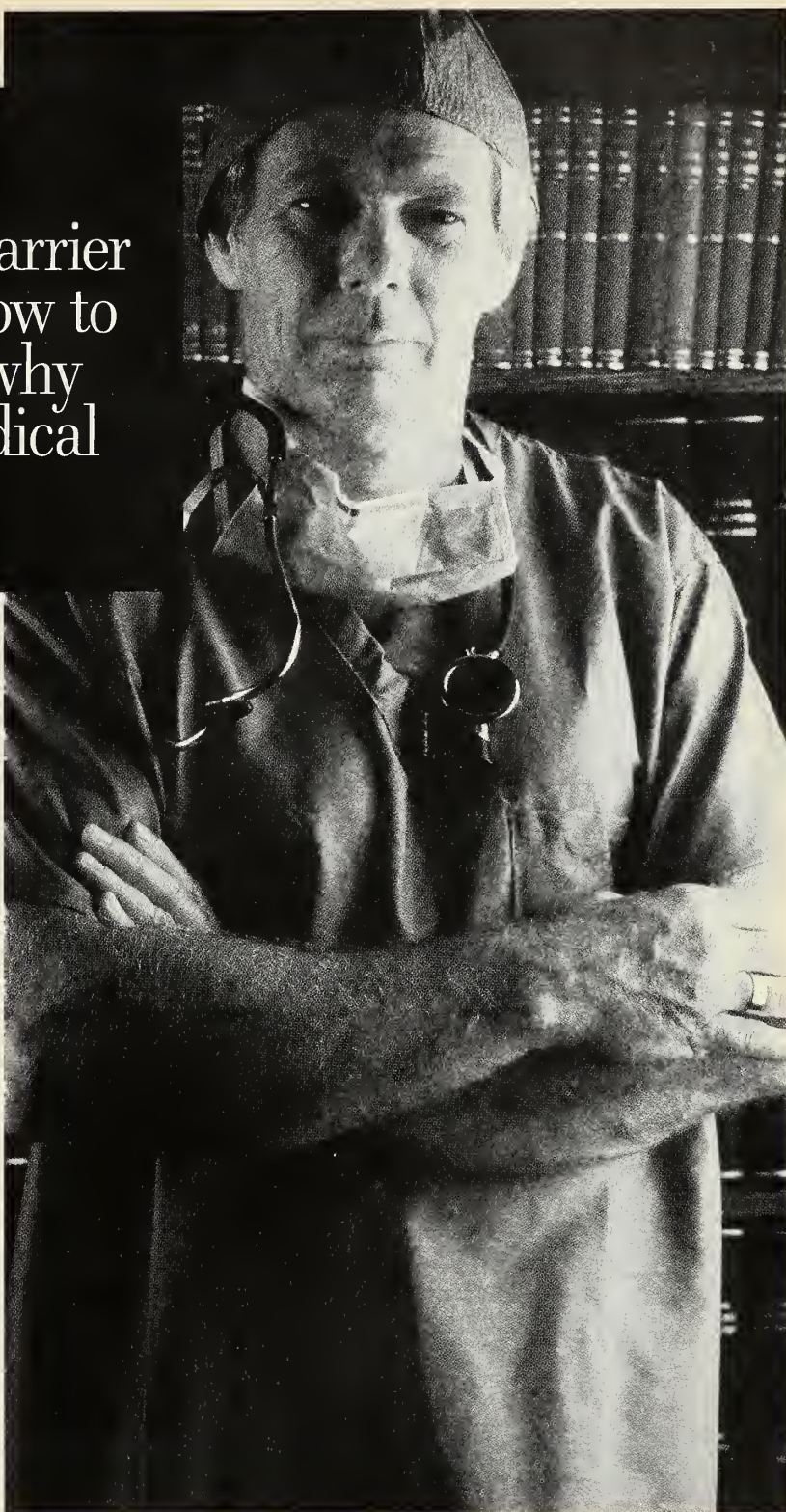
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Keeping Up

Anemia in Children

October 16, 12:00 noon. Sponsored by AHEC-Fort Smith and presented by David Becton, M.D. Sparks Regional Medical Center, 7th Floor Dining Room. CME Category I credit available.

Do We Really Need 39 Anti-Hypertensives?

October 17, 12:00 noon. Sponsored by AHEC-Fort Smith and presented by James O. Wells, M.D. Sparks Regional Medical Center, 7th Floor Dining Room. CME Category I credit available.

HIV/AIDS - Nursing Issues for the 1990's

October 18, 8:30 a.m. - 4:15 p.m. Sponsored by the Delta Regional AIDS Education and Training Center, Arkansas State Nurses Association, Arkansas Licensed Practical Nurses Association and RAIN (Regional AIDS Interfaith Network. First Presbyterian Church, Conway. Fees: \$20.00; \$10.00 students and retirees. For more information, call Eva Reynolds at 686-5000.

Loss Prevention Seminar

October 20, 9:00 a.m.-11:00 a.m. with registration from 8:00 a.m. - 9:00 a.m. Presented by State Volunteer Mutual Insurance Company and co-sponsored by the Arkansas Medical Society. Fayetteville Hilton. Two Category I credit hours. Free admission. For more information, call 1-800-633-3215 or (615) 377-1999.

1990 Arkansas Physicians Opportunity Fair

October 25, 10:00 a.m. - 3:00 p.m. Presented by UAMS. Jeff Banks Student Union, UAMS campus. For more information, contact Tom South, (501) 686-5813.

ACLS Conference - Pine Bluff AHEC

October 26-28, times to be announced. Sponsored by UAMS and presented by Donald Miller, M.D. Jefferson Regional Medical Center, Pine Bluff. Fees: to be announced. CME Category I credit available.

Annual Primary Care Update 1990

November 2, 7:00 a.m.-5:00 p.m. Presented by Baptist Medical Center's Medical Education Department, Little Rock. J.A. Gilbreath Conference Center, Baptist Medical Center, Little Rock. CME Category I credit available. For more information, call (501) 227-2672.

HIV/AIDS - Nursing Issues for the 1990's

November 6, 8:30 a.m. - 4:15 p.m. Sponsored by the Delta Regional AIDS Education and Training Center, Arkansas State Nurses Association, Arkansas Licensed Practical Nurses Association and RAIN (Regional AIDS Interfaith Network. First Baptist Church, Arkadelphia. Fees: \$20.00; \$10.00 students and retirees. For more information, call Eva Reynolds at 686-5000.

HIV/AIDS - Nursing Issues for the 1990's

November 15, 8:30 a.m. - 4:15 p.m. First Baptist Church, Jonesboro. For more information, call Eva Reynolds at 686-5000.

HIV/AIDS - Nursing Issues for the 1990's

December 7, 8:30 a.m. - 4:15 p.m. First Presbyterian Church, Monticello. For more information, call Eva Reynolds at 686-5000.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

Continuing Medical Education Luncheon, second and fourth Friday, 12:30 p.m. AMI Ozark-Quapaw Room. One Category I credit per meeting.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), third Wednesday, 12:30 p.m., Conference Room, Building 1, VAMC

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Faculty Resident Seminar, third Thursday, 12:00 noon, Sturgis Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Building, Room 457
Infectious Disease Conference, second Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Building, Auditorium
Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., 2nd Floor Classroom
Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, 2nd Classroom
Pediatric Research Conference, first Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

Interdisciplinary AIDS Conference, second Friday, 12:00 noon. LaHarpe Room. Sandwich buffet is served.
Cancer Conference, third Thursday, 12:00 noon, Laboratory Conference Room. Lunch is provided.
Hematology-Oncology Conference, second Thursday, 12:00 noon, Laboratory Conference Room. Lunch is provided.
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Southwestern Bell/Arkla Room. Refreshments are provided.
Pulmonary Conference, second and fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla Room. Sandwich buffet is served.
Journal Club, every Tuesday, 12:00 noon, Conference Room 1. Lunch is provided.
GYN Surgery Cancer Conference, second Monday, 12:00 noon, AP&L Room. Lunch is provided.
Joint Tumor Conference, first Wednesday, 12:00 noon. CARTI Auditorium. Lunch is provided.

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., Conference Room 1
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lectures and case presentations. A light lunch is provided.
Pathology Conference, third Tuesday, 3:00 p.m., Pathology Library
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. A light lunch is provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC Oncology Forum, fourth Thursday, 4:00 p.m., UAMS ACRC 2nd Floor Conference Room, 1.5 credits
Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
Anesthesia Morbidity and Mortality Conference, second and fourth Tuesdays, 6:45 a.m.; first, third and fifth Thursdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy
Child Psychiatry Clinical Case Conference/Research Review, most Fridays, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room
Dermatopathology Conference, Tuesdays, 8:00 a.m., UAMS Education Building, Room G/108 A&B
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Building, Room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Building, Room G/110A&B
Emergency Medicine Grand Rounds 1, third Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B.
Emergency Medicine Grand Rounds 2, third Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology Conference Room, #M1/293.
Hematology Fellow's Forum, second, third, and fourth Fridays, 8:15 a.m., ACRC Betsy Blass Conference Room
Hematology/Oncology Clinical Problems Conference, Thursdays, 7:30 p.m., The Terrace Restaurant
Interdisciplinary Gynecologic Cancer Conference, Fridays, 12:30 p.m., UAMS Education Building, Room G106 A&B
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., St. Vincent Infirmary Education Bldg., Arkla/Bell Room
Little Rock Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC Conference Room three times per month, CARTI Auditorium one time per month
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Building, Rom G/131A&B
Medicine Research Conference, three Wednesdays per month, 4:30 p.m. Shorey Building, Room 3S06
Neurology Clinical Case Conference, Thursdays, 8:00 a.m. VAMC-LR Room 2D109
Neuropathology Conference, Thursdays, 10:00 p.m. UAMS Morgue
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Ob/Gyn Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Building, Room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, Room 3/150, 2 credit hours
Orthopaedic Basic Science Conference, occasional Tuesdays, 11:00 a.m., UAMS Education Bldg., Room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Building, Room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Building, Room B/135

Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Building, Room B/135
Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Shorey Auditorium
Surgery Basic Sciences Conference, Wednesdays, 4:00 p.m., UAMS Chancellor's Area Conference Room B-2
Surgery Morbidity and Mortality Conference, Wednesdays, 7:00 a.m., UAMS Education Building, Room G/141A
Surgery Staff/Clinical Case Conference, alternating Tuesdays, 7:00 a.m., UAMS Education Building, Room G/141
Surgery Vascular/Radiology Conference, Tuesdays, 5:00 p.m., VAMC-LR Radiology Conference Room
Surgery Vascular Teaching Conference, Thursdays, 3:00 p.m., VAMC-LR Radiology Conference Room.
Urology Basic Sciences Conference, second Wednesday, 5:00 p.m., UAMS Education Building, Room G/106A&B
Urology Clinical Didactic Conference, third Tuesday, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
Urology Core Conference, once or twice monthly, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
Urology Grand Rounds, second and fourth Tuesday, 5:00 p.m., VAMC-LR (4D)
Urology Morbidity and Mortality Conference, last Wednesday, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
Urology Teaching Conference, once or twice monthly, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
Uro-Radiology Workshop (Urologic Imaging), once monthly, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
VA Chest Conference (combined Surgical/Medical Chest Conference), alternating Mondays, 12:15 p.m., VAMC-LR, Room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine Conference Room, Room 1D173
VA Geriatric/Gerontology Research Conference, Wednesdays, 3:15 p.m., VAMC-LR, Room 1E123
VA Hematopathology Conference, Wednesdays, 3:00 p.m., VAMC-LR Pathology Conference Room
VA Lung Cancer Conference (combined Medical/Surgical Lung Cancer Conference), Tuesdays, 3:00 p.m., VAMC-LR, Room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Building 68
VA Medicine-Pathology Conference, Tuesday, 2:00 p.m., VAMC-LR, Room 2D109
VA Medicine Service Resident's Clinical Case Conference, Fridays, 12:00 noon, VAMC-LR, Room 2A109
VA Physical Medicine and Rehab Grand Rounds, fourth Friday, 11:00 a.m., VAMC-NLR Building 68, Room 118 or Arkansas Rehab Institute
VA Psychological Assessment Conference, Tuesdays, 3:00 p.m., VAMC-LR & NLR Psychology Department, 1.5 credit hours
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, Room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine Conference, Thursdays, 8:00 a.m., VAMC-NLR Building 68, Room 118
VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology Conference Room

EL DORADO - AHEC

Behavioral Sciences Conference, first and fourth Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, second Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second and fourth Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, fourth Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, first, second and third Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

Behavioral Sciences Conference, 3rd Wednesday, 12:00 noon, Washington Regional Medical Center
City Hospital Staff Medical Meeting, second Friday, 12:00 noon, Fayetteville City Hospital
Family Medicine Conference, 1st, 3rd, 4th Thursday; 4th Wednesday; 2nd Thursday (odd months) AHEC-NW, 241 W. Spring, Fayetteville
Interesting Case Conference, 1st Friday, 12:00 noon, Fayetteville City Hospital
Medicine Conference, 1st and 3rd Tuesday, 12:00 noon, Washington Regional Medical Center
OB/GYN Conference, October 11, 12:00 noon, AHEC Conference Room
Pediatric Conference, 2nd Wednesday, 12:00 noon, Washington Regional Medical Center
Radiology Conference, October 3, 12:00 noon, Washington Regional Medical Center

FORT SMITH - AHEC

Internal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first and third Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.
Chest Conference, second Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided
Craighead/Poinsett Medical Society, first Tuesday, 7:00 p.m. Jonesboro Country Club
Eaker AFB CME Conference, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria

Independence County Medical Society, second Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, fourth and fifth Tuesday, 12:00 noon, St. Bernards Dietary Conference Room. Lunch provided.
Jackson County Medical Society, third Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, third Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, second Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neuroradiology Conference, third Friday, 12:00 noon, St. Bernards Dietary Conference Room. Lunch provided.
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Pocahontas CME Conference, third Wednesday, 12:00 noon and 7:30 p.m., Randolph County Medical Center Boardroom
Tumor Conference, 2nd Thursday, 4th Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided
Walnut Ridge CME Conference, third and last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

PINE BLUFF-AHEC

Behavioral Science Conference, first and third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second and fourth Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, first and fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, second and fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second and fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Cine Radiology, second Friday, 12:00 noon, Wadley Regional Medical Center.
Echo-Cardiology, fourth Friday, 12:00 noon, Wadley Regional Medical Center
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Neuro-Radiology Conference, first and third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

Recruiting Physicians

Growing community hospital of 63 beds in the scenic Ozark Mountains in N.W. Arkansas is seeking full time, experienced emergency physicians to staff low volume E.D. Must be BP/BC in EM, FP, or IM with ACLS. \$110K+/yr. Flexible scheduling. Part-time also available. Send C.V. to:

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Physician to work satellite clinic in Northeast Arkansas.
 Monday thru Friday, 8:00 a.m. to 5:00 p.m.
 Call (501) 932-2430

Medicine in the News

Health Care Access Foundation Update

As of August 1990, the Arkansas Health Care Access Foundation has provided free medical services to 1,785 medically indigent persons.

The program has 1,480 volunteer health care providers including medical doctors, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.

Muscle Out the Measles

According to reports from across the country, the immunization levels of pre-school aged children have decreased over the past several years. As a result of the decrease in immunization levels these children have become most vulnerable to the devastating effects of disease morbidity. In fact, many outbreaks of disease are occurring primarily in pre-school children. For example, in the first 26 weeks in 1989, there was total of 6,873 measles cases reported to the Centers for Disease Control in Atlanta. In the outbreaks, up to 88% of the vaccine eligible children were found to be unvaccinated.

The incidence rates for all age groups were higher in 1989 than in 1988; the highest were 0-4 years old (11.3 per 100,000) and 15-19 years old (11.2 per 100,000). Children five years of age accounted for 30.2% of measles cases, compared with 19.4% during the same period in 1988.

Because we have seen a steady increase in vaccine-preventable disease innovative efforts need to be directed toward reducing barriers to immunization services and toward full use of existing opportunities to vaccinate eligible children. This approach should increase opportunities for vaccine administration in highly susceptible populations and reduce transmission to infants too young for routine immunization.

The Arkansas Department of Health's Division of Communicable Disease/Immunization recognizes the critical need to effectively assess the pre-school age population in Arkansas. As long as vaccine-preventable disease are endemic in the age group effective assessment and tracking methods need to be developed to assure timely immunizations to avoid possible disease morbidity and mortality. To provide a means of identifying, locating and ultimately immunizing these children, the Center for Disease Control has awarded the Arkansas Department of Health with funding for a three year Demonstration Project. The main objectives of the Project are:

1. To access the immunization status of two year olds

not served by the Arkansas Department of Health

2. To offer private physicians the latest immunization information available
3. To provide a model for the Centers for Disease Control to present to other states interested in assessing immunization levels.
4. To develop a cooperative working relationship between the Arkansas Department of Health and physicians in the private sector.

The Demonstration Project will be conducted in three phases. The first phase, which is currently underway, is to distribute questionnaires concerning office procedures and immunizations to family physicians to participate in a one-time, on-site visit to review immunization records for two-year-old patients. The third and final phase of the Project will be the analysis and publication of the findings.

The Arkansas Medical Society supports the project along with the Arkansas Academy of Family Physicians and the Arkansas Academy of Pediatrics.

The Rights of the Patient

At its June meeting of the American Medical Society, the House of Delegates adopted the following report from the Council on Ethical and Judicial Affairs that describes six areas of fundamental rights of patients in their relationship with physicians.

From ancient times, physicians have recognized that the health and well-being of patients depends upon a collaborative effort between physician and patient. Patients share with physicians the responsibility for their own health care. The patient-physician relationship is of greatest benefit to patients when they bring medical problems to the attention of their physicians in a timely fashion, provide information about their medical condition to the best of their ability, and work with their physicians in a mutually respectful alliance. Physicians can best contribute to this alliance by serving as their patients' advocate and by fostering these rights.

1. The patient has the right to receive information from physicians and to discuss the benefits, risks and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action. Patients are also entitled to

obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their physicians might have, and to receive independent professional opinions.

2. The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.
3. The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.
4. The patient has the right to confidentiality. the physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.
5. The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient sufficient opportunity to make alternative arrangements for care.
6. The patient has a basic right to have available adequate health care. Physicians, along with the rest of society, should continue to work toward this goal. Fulfillment of this right is dependent on society providing resources so that no patient is deprived of necessary care because of an inability to pay for the care. Physicians should continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential health care.

Detoxification or Maintenance Treatment of Drug Addicts by Physicians

Federal law specifically prohibits the use of a prescription for the dispensing of any narcotic for the purpose of "detoxification treatment" or "maintenance treatment." An attempt to issue prescriptions in either of these situations could result in serious repercussions to the practitioner. Both the individual practitioner and the patient could be subject to criminal penalties (Part 1306.04 C.F.R.)

Under certain conditions the law permits practitioners to administer narcotics directly to patients for detoxification or maintenance treatment. (This does not allow for prescriptions to be written for this purpose.) Where permitted, such

activities are considered to be within the meaning of "in the course of professional practice." The following should be noted (Part 1306.07 C.F.R.):

1. The practitioner must be registered separately with DEA for this purpose and comply with FDA standards and DEA Security Regulations relating to Narcotic Treatment Programs (Parts 1301.72 - 1301.74 C.F.R.)
2. Practitioners who are not specifically registered may administer (but not prescribe) narcotic drugs to drug addicted persons for the purpose of relieving acute withdrawal symptoms while arrangements are made for referring the patient for treatment to a registered narcotic treatment program. Not more than one day's medication may be administered at a time, and such emergency treatment is only permitted for a maximum of three days.
3. None of the above limitations apply to physicians or authorized hospital staff in situations in a hospital where it is necessary to dispense or administer narcotic drugs to maintain or detoxify a patient as an "incidental adjunct" to medical or surgical treatment of conditions other than drug addiction. Also, the limitations do not apply in situations where narcotic drugs are administered or dispensed to patients with intractable pain in which no relief or cure is possible or none is found after reasonable efforts to that end have been made (Part 1306.07)

(Reference to federal law may be found in Code of Federal Regulations Title 21 Part 1300 to end.)

The History of Arkansas Medicine

The History of Medicine Associates of the UAMS Library, with assistance from the Arkansas Endowment for the Humanities, has recently published *Contributions to Arkansas Medical History*. The papers included are the winners of the first five History of Medicine Associates Research Awards. Each of the papers provide information about a different aspect of Arkansas health care.

Copies of the book are available, prepaid only, from:

History of Medicine Associates
c/o Special Collections
UAMS Library, Slot 586
4301 West Markham
Little Rock, AR 72205-7186

The cost of the book is \$15.00 plus a \$2.00 postage and handling fee. There is a special price for associate members.

The History of Medicine Associates is a support group for the Special Collections Division of the UAMS Library which includes historical books, photographs, and archival materials.

AMS Newsmakers

1990-91 AMS Officers and Council



First row: Drs. James Kolb, George Warren, William Jones, Charles Rodgers, James Weber, Lloyd Langston, J. Larry Lawson.

Second row: Drs. F.E. Joyce, David Rogers, Jerry Mann, Ronald Bracken, Linda Markland, Robert Langston, Charles Logan.

Third row: Drs. L.J. Pat Bell, Paul Cornell, John Crenshaw, Michael Moody, James Lytle, Morton Willson, A.C. Bradford, Warren Douglas, Glen Baker and Gerald Stoltz.

Joycelyn Elders, M.D., director of the Arkansas Department of Health, is one of seven recipients nationwide of National Education Association awards recognizing contributions to the advancement of human and civil rights.

Dr. Elders was cited for her leadership in promoting women's rights. She was also awarded the Mary Hatwood Futrell Award for Creative Leadership in Women's Rights.

Ross Fowler, M.D., recently ended another chapter of Harrison medical history by retiring and closing the downtown Harrison clinic his father began, and in which he worked for more than half a century.

Dr. Fowler is a charter member of the American Academy of Family Practice Physicians. He has served 15 years on the Arkansas Medical Society board of directors and 16 years on the Arkansas Medical Examining Board. He was president of the Arkansas Medical Society in 1969-70.

Cagle Harrendorf, M.D., has founded the Harrendorf Institute in Little Rock. The facility specializes on the

emotional and physical health of corporations, organizations and executive staffs. It will also offer health education, preventative medicine, and restorative care.

Paul Kramm, M.D. was recently named medical director at Central Arkansas Rehabilitation Hospital (CARH), a 60-bed medical rehabilitation facility currently under construction and scheduled to open in October in Sherwood, Arkansas.

Ted Lancaster, M.D. was elected chairman of the board of governors for Lawrence Memorial Hospital and Lawrence Hall Nursing Home in Walnut Ridge.

Taylor Prewitt, M.D., a cardiologist with Cooper Clinic, was elected to the board of trustees for St. Edward Mercy Medical Center in Fort Smith.

Sudhir Vithalbhai Shah, M.D. has been named director of the Division of Nephrology in the University of Arkansas for Medical Sciences.

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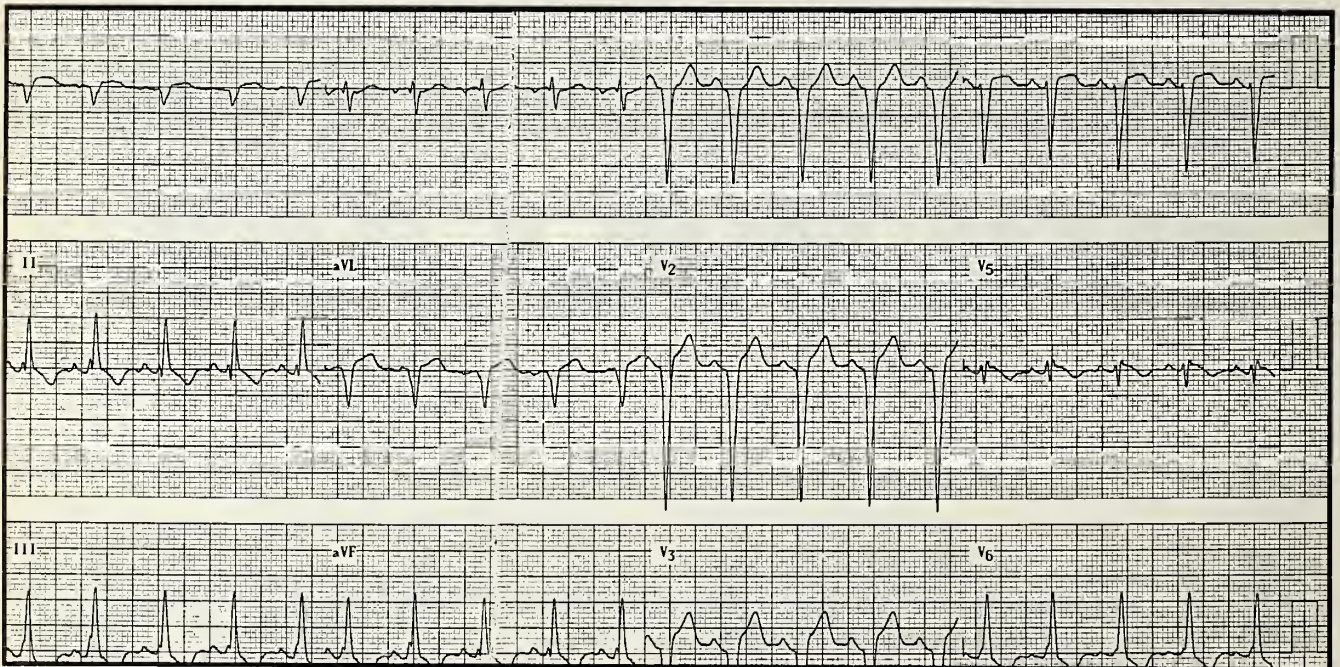
ELECTROCARDIOGRAM of the MONTH



Sam Daniel, M.D.
John W. Watson, M.D.

CLINICAL HISTORY:

J.M. is a 63-year-old lady who has presented because of chronic heart failure. Her physical examination revealed crackles in her lungs and a ventricular gallop. Her chest film was positive for cardiomegaly, right pleural effusion, vascular redistribution, and a calcified left ventricular aneurysm. What do you think of her ECG?



DISCUSSION:

The patient has sinus rhythm. QS Complexes are noted in I, aVL and V₁ - V₃ with ST elevation in these leads and V₄ as well. These changes are compatible with past myocardial infarction with aneurysm formation. The presence of calcium in the aneurysm from a radiographic point of view suggests that the infarct was relatively remote.

The editor wishes to thank Dr. Daniel of Conway for his contribution to this month's featured electrocardiogram.

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New Members

BAXTER COUNTY

Dyer Sr., William S., Internal Medicine, Mountain Home. Born May 23, 1959, Jasper, AL. Medical education, Louisiana State University, Baton Rouge, 1985. Internship/residency, UAMS, 1990. Board certified.

BOONE COUNTY

Hyewon, Kim, Radiation Oncology, Harrison. Born March 26, 1957, Seoul, Korea. Medical education, Medical College, Ewha Woman's University, Seoul, Korea, 1981. Internship, St. Elizabeth Hospital Medical Center, Youngstown, OH, 1983. Residency, Harper-Grace Hospital, Detroit, MI, 1986. Practice experience, 5 years. Board certified.

CRAWFORD COUNTY

Kale, Robert L., Anesthesiology, Van Buren. Born September 16, 1952, Willard, OH. Medical education, Ohio State University College of Medicine, Columbus, 1981. Internship/residency, National Naval Medical Center, Bethesda, MD, 1985. Practice experience, 5 years. Board certified.

GARLAND COUNTY

Hendrick, Daniel E., Anesthesiology, Hot Springs. Born May 21, 1956, Liberal, KS. Medical education, University of Kansas, Kansas City, 1983. Residency, University of Kansas-Wichita Affiliated Hospital, 1986. Practice experience, 5 years. Board certified.

PULASKI COUNTY

Baker, John W., Surgery, Little Rock. Born May 14, 1959, Snyder, TX. Medical education, LSUMC, Shreveport, LA, 1983. Internship/residency, LSU Hospital, Shreveport, 1988. Practice experience, 3 years. Board certified.

Barnes, Reginald, Cardiothoracic Surgery, Little Rock. Born February 26, 1957, Benton, AR. Medical education, UAMS, 1982. Internship, Howard University Hospital, Washington, D.C., 1983. Residency, Howard University Hospital and Tulane University Hospital, New Orleans, LA, 1990. Board certified.

Dilday, James K., General Psychiatry, Little Rock. Born March 20, 1956, Little Rock. Medical education, UAMS, 1984. Internship/residency, UAMS, 1985; University of Alabama, Birmingham, 1986; University of Tennessee, Memphis, 1990.

Diner, Bradley C., Psychiatry, North Little Rock. Born December 17, 1956. Medical education, UAMS, 1985. Internship/residency, Vanderbilt Hospital, Nashville, TN, 1989. Practice experience, 1 year.

Gilliam, David L., Orthopedic Surgery, Little Rock. Born December 6, 1957, Puerto Rico. Medical education, UAMS, 1985. Internship/residency, UAMS, 1990.

Harber, Harley J., Psychiatry-Addictions, Little Rock. Born January 10, 1950, Batesville. Medical education, UA, Fayetteville, 1971. Internship/residency, UAMS, 1979. Practice experience, 8 years. Board eligible.

Lester, Roger, Gastroenterology, Little Rock. Born December 16, 1929, New York, NY. Medical education, Yale University, New Haven, CT, 1955. Internship/residency, Salt Lake City Hospital, UT, 1960; Harvard Unit Medical School, Boston, MA, 1962. Practice experience, 28 years. Board certified.

Lewis, Laurie W., Pediatrics, Little Rock. Born April 6, 1959, Yokosuka, Japan. Medical education, UAMS, 1987. Internship, UAMS, 1988. Residency, Arkansas Children's Hospital, Little Rock, 1990. Pending certification.

Stanton, T. Michael, General & Vascular Surgery, Little Rock. Born July 16, 1955, Conway. Medical education, UAMS, 1985. Internship/residency, UAMS, 1990.

RESIDENT

Hutchison, Timothy N. Born October 6, 1958, Key West, FL. Medical education, University of Tennessee, Memphis, 1989. Internship, Methodist Hospital-Central, Memphis, TN.

STUDENTS

Almond, Jim C.
Arick, Carmen L.
Arnold, Chris A.
Baden, John G.
Baughman III, Henry J.
Bauknight, Nichole M.
Berry, Elizabeth J.
Bivens, D. Marilyn
Black, Douglas S.
Bryant, Rodney K.
Callahan, Stephen T.
Cargile, Christopher S.
Carnahan, Don A.
Carter, Todd L.
Clemons, Cara M.

Coleman, Charlotte A.
Cormier, Karen L.
Coutts II, William G.
Crowell, Stacy L.
Davis, Donna L.
Delacey Jr., Norbert W.
Dilday, Bradley R.
Dilcs, Timothy R.
Dillaha, Jennifer A.
Dicus, Scott G.
Drope, Philip B.
Dugan, Eric S.
Duke, John R.
Dunlap, Jennifer P.
Fischer, Michael C.

Fortin, Elise M.
 Foscue, David J.
 Franklin, Patricia A.
 Franklin, Sherrie R.
 Garner, Hayley M.
 Garner, Kimberly K.
 Graham, Melissa
 Graham, Tonya P.
 Gray, Irol T.
 Guin, Jason W.
 Haefner, Susan M.
 Halter, Charles T.
 Hamby, Jeffery D.
 Hardy, Hunter T.
 Hartline, Brian K.
 Hartman, Richard R.
 Hawkins, Linda S.
 Henry, Katherine E.
 Hill, Chad
 Honeycutt Jr., Johnnie H.
 Honghiran, Lalita
 Hor, Kem S.
 Horner Jr., Charles R.
 Hronas, Theodore N.
 Hudec, Wayne A.
 Jewell, Shannon A.
 Johnson, Michael W.
 Kagy, Matt K.
 Kays, Angela
 King, Brock K.
 Knapp, Katherine M.
 Knight, Michael V.
 Lahiri, Sabrina A.
 Lancaster, Shawn C.
 Lazenby, John P.
 Locke, Stephen W.
 Lum, Diane L.
 May, Julie S.
 McDonald, Lori A.

McNutt, Joseph W.
 Merritt, Charles J.
 Merritt, Mathew M.
 Mitchell, Bruce G.
 Mullins, Michael S.
 Murphy, Arlene L.
 North, Michael S.
 Penn, Zena V.
 Perkins, Richard A.
 Plumley Jr., Spencer G.
 Pullen, Charles S.
 Purifoy, Shawn W.
 Quade, Deborah S.
 Randle, Yvette I.
 Roman, Juan C.
 Russell, Debra K.
 Shaw, Rose M.
 Shultz, Joseph M.
 Siems, Martin L.
 Simmons, John R.
 Stanley J. Scott
 Stussy, Shawn A.
 Tabor, Dale R.
 Thomas, Jeffery F.
 Thomas, Johathan F.
 Thomas, Lynn C.
 Torrains, Robert
 Vinson, Sidney L.
 Walker, Brent L.
 Wewer, Darin A.
 Williams, Chrysti L.
 Wilson, Donald P.
 Woodiel, James C.
 Wu, John H.
 Wynn, Chester M.
 Young, Christopher M.
 Young, Jeffery H.
 Young, John P.

Physician's Recognition Award

The Physician's Recognition Award is awarded each month to physicians who have completed acceptable programs of continuing medical education. The recipients for the months of July and August are:

Robert D. Blasier	Little Rock
Jim L. English	Little Rock
Clinton J. Fuller	Little Rock
John M. Hestir	De Witt
Jay D. Holland	Little Rock
Tom L. Meziere	Little Rock
Randall S. Middaugh	Little Rock
Dac Tat Pham	Brinkley
Robert A. Robbins	Lake City
Douglas B. Smith	Little Rock
Wrede E. Vogel	Dermott
Paul A. Wallick	Monticello
Herman W. Westbrook	West Memphis

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Resolution

James Russell Morrison, M.D.

Whereas, the members of the Pulaski County Medical Society note with sincere sorrow the recent death of an esteemed member, James Russell Morrison, M.D.; and

Whereas, Dr. Morrison gave generously of his time and talent to this Society for over three decades, serving in numerous capacities including vice president in 1966; and

Whereas, he was a past president of the Arkansas Chapter of the American College of Radiology, and a long-time member of the American Medical Association; and

Whereas, Dr. Morrison's concern for the well-being of his patients was widely known; be it therefore

RESOLVED, that this resolution be adopted and made a part of the permanent records of this Society; and

RESOLVED, that a copy of this resolution be sent to Dr. Morrison's family as an expression of our heart-felt sympathy; and

RESOLVED, that a copy be sent to *The Journal of the Arkansas Medical Society* for publication.

Adopted
Executive Committee
August 15, 1990

By Order of the Memorials Committee
Marlon J. Doucet, M.D., Chairman
Henry Hollenberg, M.D.
Robert Watson, M.D.

*Memorials honoring Arkansas Medical Society members and their spouses
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Call the Society at (501) 224-8967 or 1-800-542-1058 for more information.

In Memoriam

Bette A. Wilson

Mrs. Bette A. Wilson, former medical records librarian at the Sparks Regional Medical Center and librarian at the Holt-Krock Clinic in Fort Smith, died Thursday, August 30, 1990. She was 69.

Mrs. Wilson served as state president of the Arkansas Medical Society Auxiliary from 1976-77. She is the widow of Carl Wilson, M.D.

Mrs. Wilson is survived by a son, Scott Stuart of Van Buren; two stepsons, Dr. Steve Wilson of Fort Smith and Dale Wilson of Houston, TX; two sisters, Winifred Wright of Barling and June Guilfoil of Kansas City, MO; and five grandchildren.

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Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hypotension, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, Drug Interactions and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause granulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: **General:** **Impaired Renal Function:** As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (>5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See Drug Interactions.)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methylglucosides, calcium-channel blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy—Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not

been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of 14 C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 10% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, Hypotension); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances; atrial fibrillation; palpitation.

Digestive: Ileus, pancreatitis, hepatitis (hepatocellular or cholestatic jaundice), melena, anorexia, dyspepsia, constipation, glossitis, stomatitis, dry mouth.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, hyperhidrosis.

Special Senses: Blurred vision, taste alteration, anosmia, tinnitus, conjunctivitis, dry eyes, tearing.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgias, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings:

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g/dL and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: **Hypertension:** In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance > 30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤ 30 mL/min (serum creatinine ≥ 3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, Pharmacodynamics and Clinical Effects.) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Patients with Heart Failure and Renal Impairment or Hyponatremia: In patients with heart failure who have hyponatremia (serum sodium < 130 mEq/L) or with serum creatinine > 1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, Heart Failure, WARNINGS, and PRECAUTIONS, Drug Interactions.) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

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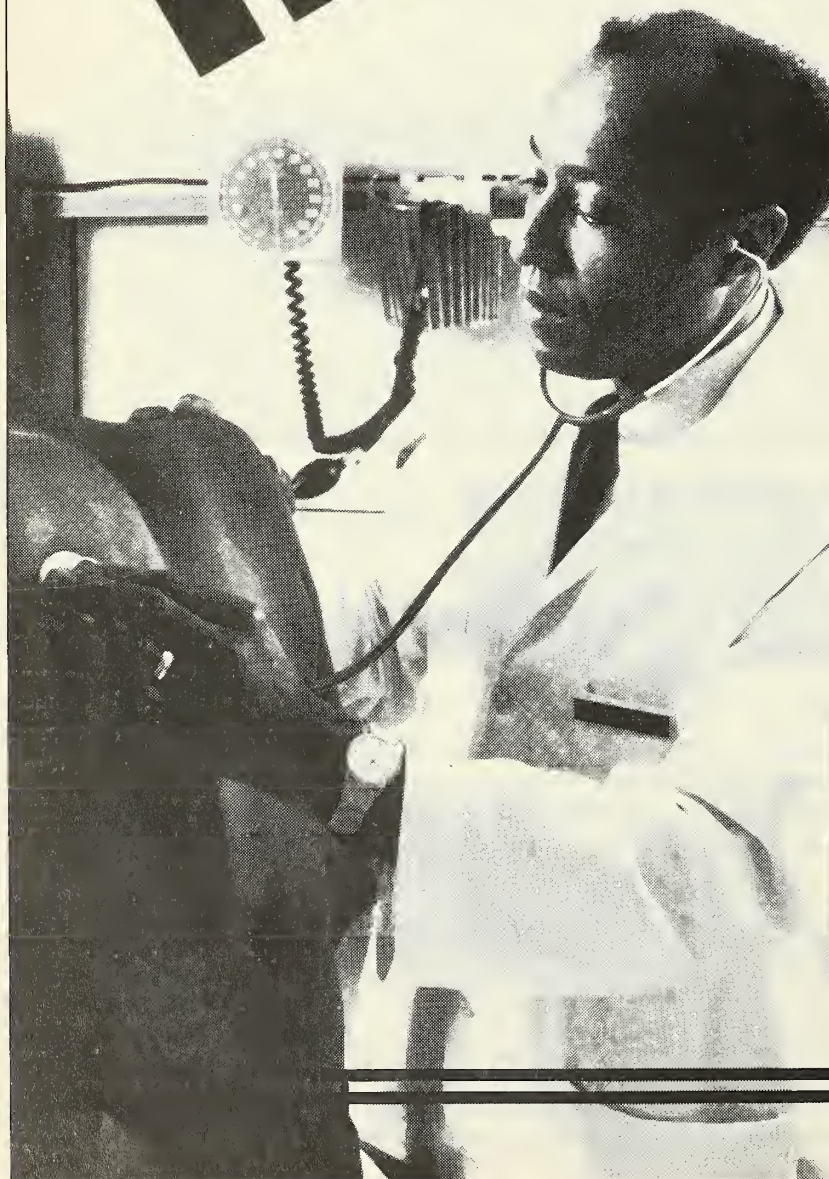
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Substance Abuse Among Pregnant Women More of A Problem Than You Might Think

Cynthia C. Crone, RNP*

Curtis L. Lowery, M.D.**

Perinatal substance abuse has received broad media coverage recently and because of this, doctors and nurses have begun to identify pregnant women who abuse alcohol, tobacco and other drugs. This increased recognition is reflected in Arkansas by the rising number of referrals for substance abuse to the University of Arkansas for Medical Sciences High Risk Pregnancy Program. Those patients who are referred, however, only reflect the tip of the iceberg.

The effects of substance abuse during pregnancy have been documented by a number of researchers.^{3,6,7} Commonly reported effects include: pregnancy complications such as spontaneous abortion, abruptio placenta, and premature labor; fetal effects such as intrauterine growth retardation and anomalies; and infant effects such as prematurity, birth defects, increased risk for Sudden Infant Death Syndrome, increased risk for child abuse and neglect, and significant neurobehavioral abnormalities.

Adverse effects of maternal substance abuse are associated with the use of both legal and illegal substances. Almost universally, women who use illicit substances also smoke cigarettes, a highly addictive legal drug. In addition to its connection with other drugs of abuse, cigarette smoking has been directly linked to poor pregnancy outcomes in numerous studies, even when it is the only drug of abuse.^{1,8,10} Dr. Louis W. Sullivan, secretary of Health and Human Services, stated that: 1) women who smoke during pregnancy double the risk that their infant will die; 2) one-fourth of all low birthweight births are attributable to maternal smoking during pregnancy; and 3) the annual savings from elimination of smoking by pregnant women would be \$750 million, \$150-200 million to the Medicaid program.¹²

Another legal drug - alcohol - has been linked to Fetal Alcohol Syndrome (FAS), a condition characterized by physical defects, mental retardation, and developmental delays in infants born to women who have abused alcohol during pregnancy.^{1,5,14} Fetal Alcohol Syndrome also costs millions of dollars in long-term care and lost potential, and can be completely prevented if pregnant women abstain from drinking alcohol during pregnancy.

The June 1990 United States General Accounting Office (GAO) report, "Drug Exposed Infants: A Generation at Risk" reported that a drug-exposed child in need of long-term services for significant physiologic or neurologic impairment may require \$750,000 in general health care and rehabilitation services to age 18.¹³ The human and economic costs become even more staggering when one considers the future impact on the social welfare and educational systems as well as the predisposition for these infants to develop their own alcohol, tobacco and other drug abuse problems in their later lives.

While awareness of perinatal substance abuse increases, there is also evidence of actual increased drug use among pregnant women.⁹ NIDA estimated that 15% of women of childbearing age are current substance abusers. Of these, approximately 34 million consume alcoholic beverages, more than 18 million are current cigarette smokers, and more than six million are current users of an illicit drug. Unfortunately, hospital and prenatal care procedures do not adequately identify drug use during pregnancy. There are no reliable data on the number of drug-exposed infants born each year, either in the United States at large or in Arkansas, specifically.

A number of studies have attempted to describe the prevalence of perinatal substance abuse, citing rates for illicit drug use ranging from 11% in a survey of 36 delivering hospitals representing all geographic areas of the United States² to 15% in a study of 17 prenatal clinics serving both

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public and private patients in Western Florida,⁴ to 20% in one Arkansas private obstetrical clinic that we have had communication from. Research has demonstrated that the problem crosses all geographic and socioeconomic boundaries. It is not a problem of a particular locale, race, or income level.

As a first step in assessing the scope of tobacco, alcohol, and other drug abuse among pregnant women in Arkansas, the Arkansas High Risk pregnancy Program and the Robert Wood Johnson Foundation's Arkansas Healthy Futures Program conducted a survey of health care providers in December 1989, to assess provider perceptions of the perinatal substance abuse problem within their practices. Of the 307 respondents (about half physicians and half nurses), 61% reported that substance abuse was a problem in their practice.¹¹ Estimates of prevalence of abuse for specific substances closely mirrored percentages described by others across the nation. Practitioners in West-central and South-west Arkansas perceived the greatest problem. Seventy-eight percent of Arkansas providers responding to the survey believed that special facilities should be available to care for pregnant women, who abuse substances, and their children.

One Hot Springs obstetrical clinic routinely performs urine screens for substances of abuse on all prenatal patients. That practice, which is comprised of a half private insurance and half Medicaid patient population, reports a 20% positive rate for illicit substances on entry to prenatal care.

To further assess the scope of this problem in Arkansas, the Arkansas High Risk Pregnancy Program, is seeking funding to perform anonymous urine analyses for substances of abuse among a random sample of Arkansas women presenting for delivery. Such a study would aid in defining the problem of maternal substance abuse in Arkansas by providing objective data to be compared with the providers' subjective survey reports. Such information would be used to identify education and service needs.

To prevent substance abuse by pregnant women, abusers must first be identified. Following that, there is a major need for quality, accessible treatment services for substance abusing pregnant and postpartum women and their children. It is essential that identification and treatment services remain under the direction of health providers since chemical dependence is a disease.

Interventions must be anchored by treatment in a supportive health environment rather than interdiction using a criminal, punitive approach.

For interventions to be successful, family-centered outreach and treatment services must be tailored to the diverse and complex needs of this population. A true multidisciplinary team approach which recognizes the biologic, psychologic, and social domains of treatment is essential. Professionals in the field of chemical dependence treatment and perinatal care must work together to plan, coordinate, and implement treatment for this special population. Professionals will need to be cross-trained in substance abuse and perinatal care. Until now, perinatal providers have basically ignored the substance abuse needs of their pregnant patients

and the chemical dependence professionals have ignored specific issues related to pregnancy and perinatal care. Not uncommonly, women have been refused admission to a substance abuse treatment program because they were pregnant.

Thirty day residential treatment is often inadequate for pregnant or postpartum women who are chemically dependent. For those pregnant and postpartum women and their children who need it, housing during treatment for substance abuse frequently presents a major problem. This is also true after residential treatment, when a chemical-free living environment is needed. Chemical-free living environments (half-way houses) for these women and their children may be needed for 12-18 months while the families achieve successful transition into the community at large. Long-term maternal follow-up will be essential in promoting recovery as is long-term health and developmental follow-up of the infant. Parenting classes and support groups will be needed, as there are special parenting challenges associated with the care of infants and children who were drug-exposed in utero. Public health and child protection workers may also need to become involved.

Obstetrics, pediatrics, pharmacology, and chemical dependence professionals at UAMS are interested in coordinating existing public and private services available for this population and identifying needed service gaps. UAMS professionals are working to design a model consultation, referral, and treatment service to offer comprehensive care for these families. Concurrently, the Arkansas Drug and Alcohol Abuse Prevention program is seeking funding to open a residential and chemical-free living facility specifically for pregnant and postpartum women and their children.

In summary, perinatal substance abuse is a major problem in this nation and state. Long-term sequelae include death, social decay, and costly long-term handicapping conditions. Currently, the state lacks an organized plan to successfully address the many problems associated with perinatal substance abuse. UAMS professionals are working to address the void. Arkansas' providers can help now by counseling all women of childbearing age regarding the dangers of tobacco, alcohol, and other drug use during pregnancy. Routine, specific, sensitive, and nonjudgmental history-taking can identify the pregnant woman who may be abusing substances and is in need of further assessment or treatment. Special treatment services must remain in the health realm and be made accessible to this population. Working together, Arkansas health professionals can make a difference in the future for these women, their children, and our state.

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Brief Summary.

Consult the package literature for prescribing information. Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Cecilor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of non-susceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Cecilor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Cecilor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions have been reported with the use of Cecilor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, serum-sickness-like reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Cecilor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.

- Stevens-Johnson syndrome, toxic epidermal necrolysis,

and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.

- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

Abnormalities in laboratory results of uncertain etiology:

- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
- Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Cecilor and Coumadin concomitantly.
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinistix® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).

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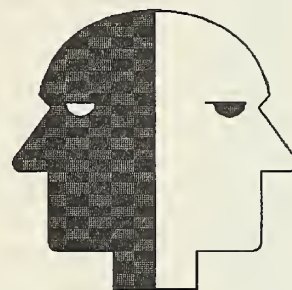


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Cerebral Laterality As A Basis For A New Model of Psychiatric Treatment

Gene W. Reid, M.D.*



In 1981, a Cal-Tech scientist named Roger Sperry won the Nobel Prize in Physiology and Medicine for his discovery of the differences in specialization between the left and right cerebral hemispheres. Sperry's research was done with surgically commissurotomy patients and revealed the left (dominate) hemisphere to be verbal, analytical and the seat of linear forms of logic such as mathematics. The right (minor) was found to be musical, spatio-temporal, and non-verbal in character. Of extreme interest to behaviorists was Sperry's conclusion that each hemisphere housed a separate personality, each capable of equal degrees of awareness and volition. Sperry believed the right hemisphere's personality was equally self-aware with the left hemisphere. In Sperry's own words: "All results to date support the conclusion that the right hemisphere, despite its language deficits, harbors a well-developed, seemingly normal conscious self with a basic personality and social self-awareness that is in close accord with the presurgical character of the patient and also with that of the speaking hemisphere of the same subject."¹ A stormy debate of this question has never been settled in the scientific community. Probably the major torch-bearer for the dissenting side of the question of two centers of awareness is Sir John Eccles, also a Nobel Laureate in Physiology. Eccles concluded that right (minor) hemisphere did, indeed, house a separate personality, but the left (dominate) hemisphere was the seat of normal human self consciousness and that right (minor) hemisphere's level of consciousness was somewhere between left hemisphere and higher apes.² Having examined both arguments, I find the major weight of evidence favoring Professor Sperry's model in which two very different, but equally aware centers of consciousness and will function cooperatively in tandem under ordinary circumstances, producing, what we normally observe to be one entity or personality.¹

Flor-Henry and associates³ have ventured to study psychopathology from the standpoint of a theory which would allow for differences in specialization in cerebral laterality. Flor-Henry concluded that non-dominant hemisphere is more involved in mood disorders (e.g. depression) while dominant hemisphere is implicated more in thought disorders: "Taken as a whole the EEG studies reported in this volume indicate a left hemisphere laterality effect in Schizophrenia and abnormal neural electrophysiological events in the right hemisphere in depression."³ In his book, Flor-Henry makes a statement which stands in direct disagreement with the present reductionist philosophy of the American Psychiatric Associations' diagnostic and statistical manual:⁴ "Our neuropsychological data indicates the presence of a continuum of increasing cerebral disorganization least in neurotic depression, greater in psychotic depression, more severe in mania, and maximal in schizophrenia."³ Whether or not we accept Flor-Henry's theories, the fact still remains that two of the worlds most distinguished scientists, Sperry and Eccles, have agreed that at least two centers of consciousness are at work in the normal being. This so called "vertical split" in consciousness was described by a physician named Wigan in England in 1844.⁵ Wigan's conclusions, based on brain autopsies, are an astounding prophecy of the findings which would win Roger Sperry the Nobel Prize nearly a century and a half later.

My assertion is that there are, indeed, two centers of consciousness and volition active in the human mind and the degree of normal or abnormal psychological functioning of the individual is determined, in major part, by the degree of cooperation between these two centers.

This theory would explain a great deal of poorly understood psychiatric phenomena. If we look at schizophrenia for example, it would provide an explanation for the associated auditory hallucinations of this disease as has been described by Jaynes.⁶ Even more profound, it would explain the universal symptom common to schizophrenia of believ-

* Dr. Reid is a Little Rock psychiatrist.

ing one's self to be possessed or controlled by an alien force. In ancient times, the alien force was identified by the sufferer as witches or demons and such. Today the schizophrenic's delusions are more likely to involve the CIA, KGB, cosmic rays and other more "timely" sources of threat. What may be actually happening is that the verbal left hemisphere's center of consciousness perceives the existence and influence of an estranged non-verbal right hemisphere's corresponding center of consciousness and proceeds to develop an explanation for this perception that is consistent with current information available from the external world through the senses. The most obvious corollary is the conclusion that the classic paranoid symptom of feeling constantly watched may, practically speaking, be valid and not a "delusion" after all. Regarding other, more bizarre, delusions found in Schizophrenia, Springer and Deutsch, commenting on commisurotomy patients in a review book of laterality research, concluded: "It is very common for the verbal left hemisphere to try to make sense of what has occurred in testing situations where information is presented to the right hemisphere. As a result, the left brain sometimes comes out with erroneous and often elaborate rationalizations based on partial clues."⁷

To quote Eugene Blueier, the physician who coined the term schizophrenia, "There is no better testimony to the value of a psychological theory than its applicability in psychopathology."⁸ A laterality-oriented theory would predict that nonverbal (right-brain oriented) psychotherapies such as music and dance therapies would be of greater therapeutic value in the treatment of "thought" disorders such as schizophrenia than traditional verbal therapies. This would be predicted because a potentially healthy (or "healthier") right hemisphere could be accessed directly instead of trying to mediate through a dysfunctional left hemisphere with words alone. If, as Sperry predicts, there is a nonverbal, aware entity present in every individual, that awareness could theoretically be communicated with through music, movement arts, and other nonverbal means, and somehow enlisted as an ally in helping the more dysfunctional hemisphere and assisting the individual as a whole back to a healthier state.

Case Reports

Case #1 - Music Therapy

Mrs. B. Was a young male in his early twenties. He was admitted to the acute psychiatric unit of the North Little Rock VA Hospital in 1984. He had the manic energy, pressured speech, and grandiose delusions of a man with acute mania. He believed himself to be a prophet of God. He experienced auditory hallucinations and displayed violent behavior, lashing out at staff members and setting fires in his room. Even with high doses of medication and treatment with Lithium he continued to be hostile and threatening. No one could establish rapport with him. One morning I was playing guitar in the day room of the unit, which I did weekly as a form of socializing. As I began to sing an old blues song call, "Bring It On Home To Me", to everyone's surprise, this man began

to sing with me. We sang the entire song together and from that day Mr. B. was no longer hostile or aggressive. His recovery from that point was speedy and he went home soon afterward.

Case #2 - Music Therapy

Mrs. E. was a woman in her late thirties. She had been diagnosed as having paranoid schizophrenia since she was a teenager. When I first met her as her doctor in the hospital, she walked around staring into space and was very bizarre and impulsive in her behavior - striking out, running off, removing her clothing, etc. Medication did not seem to help much as was reported in her previous hospitalizations. This lady sat on the periphery of our weekly music group and gradually worked her way in, singing along with songs she knew and eventually teaching me some of the songs she had learned as a child from her grandmother. Her erratic behavior stopped and she became a "model" patient, requiring only a small amount of medication to ease some of her psychotic symptoms.

Case #3 - Dance Therapy

Silberstein,⁹ after a thorough literature review of the relationship between movement dysfunction and Schizophrenia, describes the case of Mr. K., a 65-year old man who had been hospitalized for forty years as a mute schizophrenic, catatonic type, withdrawn. Medication and shock treatments had failed to help this former law school student. Working with Mr. K. as a dance/movement therapist, Silberstein eventually elicited the first attempts at communication from this patient in decades. Over a period of several months, Mr. K. reached a point where he talked, read, participated in ward activities, and went on outings. He was not cured, but the increase in his ability to care for himself obviously produced a significant decrease in the number of nursing man-hours required to attend to him and helped a human being re-emerge from a self-imposed exile of two generations in time.

Discussion

There is ample theoretical and clinical evidence to support the efficacy of treatment modalities for psychiatric illness utilizing therapies which target the non-dominant hemisphere. These would include music, dance, poetry, art, drama, and other forms of creative arts therapies. To my knowledge, there are no organized creative arts therapies programs in either the public or private mental health sectors in this state. I call for such programs to be instituted as quickly as possible.

In this paper I have focused on the relationship between laterality and schizophrenia, recognizing the overlay with depression and bipolar illness as well. In a future paper I will deal more directly with laterality and mood disorders and eventually address such syndromes as self-mutilation, drug addiction, and the process known as Multiple Personality Disorder.

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FAMILY/ER

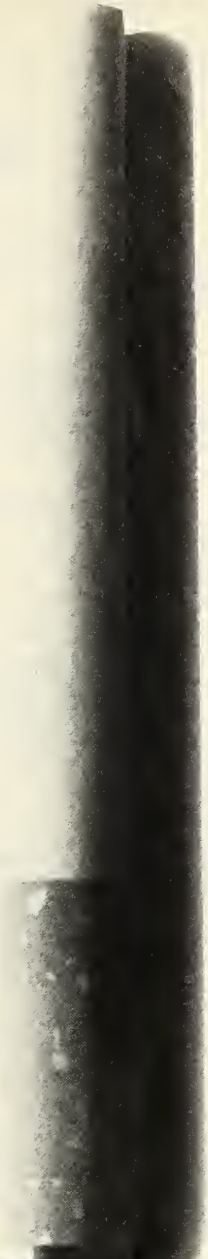
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AIDS IN ARKANSAS 1990

January 1 - December 31, 1990

Total number of cases reported		147	CASES BY AGE GROUP	
Number of deaths		11	Less than 20	9
			20 - 29	44
			30 - 39	62
			40 - 49	26
			50 or more	6
CASES BY SEX				
Male	133			
Female	14			
CASES BY RACE			OPPORTUNISTIC DISEASE	
White	108		Pneumocystic Carinii	68
Black	37		Cryptococcosis	4
Other	2		Kaposi's Sarcoma	1
CASES BY RISK GROUP			Candida	24
Homosexual/Bisexual	89		HIV Wasting Syndrome	21
Homosexual & IV Drug User	15		Toxoplasmosis	4
IV Drug User	17		HIV Encephalopathy	8
Hemophiliac	4		Histoplasmosis	9
Transfusion	6		Other Diseases	8
Heterosexual (Contacts)	6			
NIR*	9			

* No identified risk group (NIR)

AIDS IN ARKANSAS 1985 - 1990

Total number of cases reported		400	CASES BY AGE GROUP	
Number of deaths		235	Less than 20	12
			20 - 29	126
			30 - 39	177
			40 - 49	59
			50 or more	26
CASES BY SEX				
Male	365			
Female	35			
CASES BY RACE			OPPORTUNISTIC DISEASE	
White	300		Pneumocystic Carinii	189
Black	95		Cryptococcosis	19
Other	5		Kaposi's Sarcoma	12
CASES BY RISK GROUP			Candida	52
Homosexual/Bisexual	253		HIV Wasting Syndrome	38
Homosexual & IV Drug User	43		Toxoplasmosis	7
IV Drug User	44		HIV Encephalopathy	24
Hemophiliac	6		Histoplasmosis	25
Transfusion	18		Other Diseases	34
Heterosexual (Contacts)	19			
NIR*	17			

* No identified risk group (NIR)

Source: Arkansas Department of Health.

A Note To Physicians

Important New Information on ddI (didanosine) From the Clinical Trials and Expanded Access Program*

Purpose

The purpose of this document is to provide physicians with important new information about the experimental anti-HIV drug ddI (didanosine) based on the experience of more than 10,000 patients who have received the drug through clinical trials and expanded availability.

In the fall of 1989, three nationwide controlled clinical trials were opened. These are being conducted by the AIDS Clinical Trials Group (ACTG) of the National Institute of Allergy and Infectious Diseases (NIAID) in collaboration with the drug manufacturer, Bristol-Myers Squibb Company. In addition, through a Treatment IND and an open label protocol, Bristol-Myers Squibb has provided ddI to individuals unable to take AZT (zidovudine), the only approved anti-HIV therapy. The new information about ddI that continues to emerge from these programs is being provided to help physicians gain a better understanding of the drug's clinical profile as they consider its use for their patients with AIDS.

Phase I Findings

As originally reported (Science 245:412-415, 1989) and supported with additional data recently published (NEJM 322:1333-1340, and 1430-1435, 1990), the administration of ddI is associated with significant decreases in serum p24 antigen levels and statistically significant increases in the numbers of CD4+ cells. The authors of these Phase I studies concluded that ddI had considerable potential as an anti-HIV therapeutic agent in patients with AIDS or AIDS related complex.

Phase II Status

Three Phase II clinical trials that are designed to establish definitively the safety and efficacy of ddI opened last fall

and are continuing to accrue patients. Two studies compare the safety and efficacy of ddI and AZT; the third study evaluates the use of ddI in patients who have experienced hematologic intolerance while receiving AZT. Physicians are strongly encouraged to consider referral of eligible patients to these Phase II trials as the first choice for ddI therapy, as these studies provide state-of-the-art ddI therapy in a closely monitored research environment. In addition, completion of these studies is essential to achieve a full understanding of ddI's long-term efficacy and safety.

Additional information on these trials can be obtained by contacting the AIDS Clinical Trials Information Service (ACTIS) at 1-800-TRIALS-A. Physicians, especially those who have previously recommended patients for the two clinical trials comparing ddI and AZT, will be interested to know that the entry criteria have been broadened.

Expanded Access

The Bristol-Myers Squibb expanded access program was instituted to provide ddI to certain patients with HIV infection who are clearly in need of an alternative to the standard therapy of AZT but are ineligible for the Phase II trials. To obtain more information on this program, the Bristol-Myers Squibb VIDEX (didanosine, ddI) Information Center can be contacted at 1-800-662-7999.

Side Effect Profile

Because a total of more than 10,000 patients have received ddI, the safety profile of this agent is better understood than is the case with most investigational agents at this stage of drug development. Overall, the drug appears to be well tolerated; it does not produce the significant hematologic toxicity of AZT, although other toxicities do occur. The major toxicities of ddI are:

1. *Pancreatitis*

Phase I ddI studies showed that pancreatitis is a potential toxicity of ddI therapy. Physicians must be aware of the

* This program is associated with the Division of AIDS, National Institute of Allergy and Infectious Diseases, National Institutes of Health, Bethesda, Maryland.

possible risk of pancreatitis in HIV-infected patients who are receiving ddI. The apparent incidence of pancreatitis is 1.5% among patients in the Phase II studies and <2% in patients enrolled in the expanded access program. Of all patients receiving ddI, <0.2% have developed fatal pancreatitis. While current analysis of the relative risk of pancreatitis reveals no relationship to weight-adjusted dose, there appears to be a strong correlation with prior history of pancreatitis and with advanced HIV disease and poor clinical status.

To decrease the risk of pancreatitis, physicians should consider these precautions:

- * Screen all new patients prospectively for a history of pancreatitis, and advise against ddI for patients with previous pancreatitis.
- * Alert patients to the possible risks of concurrent use of alcohol and of drugs with known or suspected toxic effects on the pancreas.
- * Have patients avoid, whenever possible, the concomitant administration of ddI and other agents that may cause pancreatitis.
- * Have patients requiring therapy for acute *Pneumocystis carinii* pneumonia (PCP) discontinue ddI during acute PCP therapy and for a week following completion of PCP treatment.
- * Physicians should be alert to, and should alert their patients to watch for, signs and symptoms consistent with pancreatitis (e.g., abdominal pain, nausea and vomiting, hypocalcemia). It is suggested that patients experiencing any of these signs or symptoms should be evaluated promptly and ddI treatment stopped until pancreatitis is clearly ruled out.

2. *Diarrhea*

Diarrhea, the most commonly reported side effect of ddI, appears to be a reaction to the citrate/phosphate buffer that is used in the current formulation. Usually the diarrhea

can be managed by symptomatic treatment. It is anticipated that new product formulations now being developed by Bristol-Myers Squibb will eliminate this problem.

3. *Peripheral Neuropathy*

Peripheral neuropathy was one of the major dose-limiting toxicities reported in the Phase I ddI studies. The doses established for both the Phase II controlled trials and the expanded access program are well below the dose levels at which significant development of peripheral neuropathy was seen in Phase I. Therefore, while peripheral neuropathy is still being reported, the changes in dose in the current trials have reduced the incidence of the problem.

4. *Electrolyte Abnormalities*

Electrolyte abnormalities, including hypokalemia, hypocalcemia, and hypomagnesemia, have been reported in some patients receiving ddI and in rare cases have been associated with cardiac arrhythmias or convulsions. Thus, patients with signs or symptoms suggesting disordered fluid and electrolyte imbalance require careful monitoring.

Summary

As a more complete safety profile of ddI begins to emerge, it is clear that this agent continues to hold promise as an option for the treatment of primary HIV disease in certain patients. The long-term efficacy and safety of the drug can be fully understood only from the results of controlled clinical trials. To speed this process, the assistance and cooperation of all physicians in identifying and referring patients to the controlled trials is requested. Completion of these studies is essential and critical to a full understanding of the use of this drug in the treatment of patients with HIV infection.

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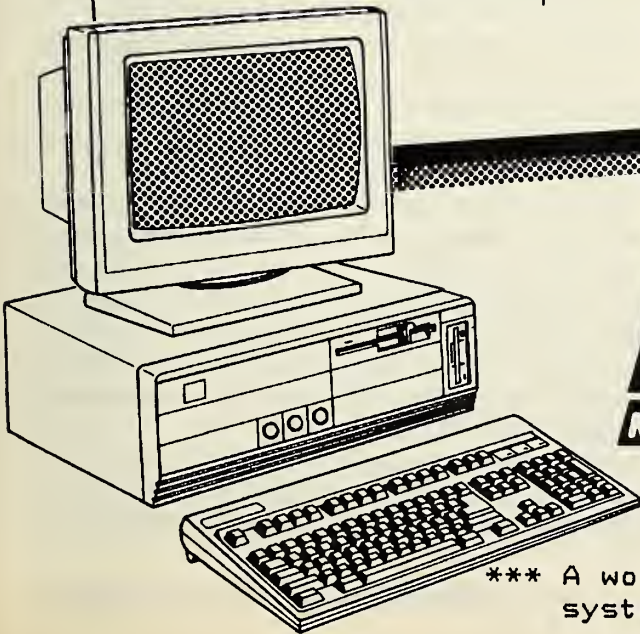
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Immunizing Against Whooping Cough



Cindy Conkle, RN, ARM*

Almost 10,500 pertussis cases were reported to state health departments between 1986 and 1988. Two-thirds of those cases involved children ages seven months to four years and potentially could have been prevented by proper immunization.¹ Although the pertussis vaccination is considered a routine immunization, some children may react seriously as the following case illustrates.

Case History

A 17-year-old woman gave birth to a 7 pound, 10.5 ounce boy, without complications, in January 1975. APGAR scores of eight and nine were recorded at one and five minutes respectively. The mother experienced episodes of tonsillitis and pharyngitis prior to pregnancy, at 34 weeks gestation, and the day after delivery along with monilial vaginitis at 15 weeks gestation. The physician noted that the infant had petechiae on the face at birth and one episode of gagging and feeding poorly. However, he ate normally at other feedings.

Office records for visits in February, March, and early May indicate that "the child ate well, weighed 14 pounds, 4 ounces in May, negative PKU, HEENT o.k., chest clear, cardiovascular systems o.k., and abdomen normal." The child was eating cereal and fruit. He had a slight cold on the second visit. At the third visit, the baby was given his first DTP immunization. Following this office visit, he slept until the mother gave him supper around 5:00 p.m. The child felt warm, but the mother didn't take his temperature. She said he was "fretful", whiny, irritable, and whimpering more than usual, and remained so for several days.

During the next three days, he began vomiting one or two times per day. (It is not known whether this was in relation to his feedings.) No temperature was taken during this time.

Four days after the visit, the child began uncontrollable

high-pitched screaming. The mother took him to an LPN who lived in the same apartment building. The LPN noticed a bulge in the groin of the child and told the mother to take the baby to the hospital. The mother took him to the hospital and a left inguinal hernia was diagnosed. The hospital physician's notes read: "repair of the left inguinal hernia. Has been a fussy baby on occasion and has had episode of what appeared to be projectile vomiting. Head and neck normal. Has been crabby for a few days." The child was discharged from the hospital the next day.

Three weeks later, the child's physician discovered an incarcerated right inguinal hernia and hospitalized him. The hospital record noted that the hernia was repaired, a head and neck exam was negative, and the child vomited prior to admission. No neuro exam was noted. The nurse's notes at 6:00 p.m. following the hernia repair read: "seems to shiver periodically" and at 8:30 p.m.: "parents had not come to see the child since admission." The child was discharged from the hospital the next day.

The surgeries and anesthesia recovery were normal, however the child was slow to wake up following the second surgery and received oxygen for 25 minutes.

The child's physician examined him twice in mid-June. He noted that the child "looked o.k." other than that the boy tilted his head to the left and back more than usual. He gave the baby his second DTP and OPV after the second June appointment.

On the fourth day following the second immunization, the baby, now five months old, began a high-pitched screaming and cried inconsolably. The child also extended and stiffened his legs and bent his toes downward. It was very difficult to move his legs. The child continued the high-pitched screaming for three days. The mother did not contact the physician because she thought the child was irritable due to hot weather and missed naps.

In early July, the child's aunt noticed that he was listless. She told her sister the child should be seen by a physician. The mother took him to a pediatrician three weeks later for

* Ms. Conkle is a registered nurse and health care manager for St. Paul Fire & Marine Insurance Company.

difficulty in breathing and holding his head up. The examination revealed poor head control and hyperactive deep tendon reflexes overall. The pediatrician noticed that the child had a high, arched palate and that the baby was grossly retarded. He told the parents that the baby was retarded and transferred the care of the boy to a local university for further care.

The parents took the boy to the university to be examined in mid-August. Several tests were performed: urine metabolic screen, skull x-ray, amino acid and TORCH - all of which were unremarkable. An EEG showed a moderate abnormal sleep record due to frequent bilateral central spikes that were occasionally associated with some generalized spike and wave activity. There were also occasional independent spikes that were excessive, diffuse, slow for the age of the child. Seizures were noticed by the physician while the EEG was being performed.

The examination revealed the following conditions in the child: severe quadriplegia with limited movement, extremely brisk deep tendon movement, bilateral Babinski's reflex, hypertonic neck musculature, positive tonic neck and moro reflex, but no parachute response could be demonstrated and the child's typical prone position was opisthotonic with his head turned to the right. The child was unable to sit or roll over but could stand if supported. After dilation of his eyes, the funduscopic exam revealed light pigment deposits in both eyes, but more prominent in the left eye. This area of pigmentation was diffuse in the left eye and not just confined to the macular region. The university physicians concluded that the baby had psychomotor retardation along with significant spasticity of unknown etiology.

The medical history taken at the time of the exam revealed that the mother's pregnancy was complicated by her taking a muscle relaxant in the sixth month. The family history did not reveal any neurologic disorders. The mother thought the child was developing normally because he was able to follow objects, smiled by three months of age, and babbled and said "ma" by four months. The child was able to grasp his bottle and would hold it to feed himself.

In early September, the parents took the now, 7 1/2 month old child back to the university to be tested for a seizure disorder. Viral titers were done at this time with the CYTO 1:8, Rubella was less than 15, the HSV was less than 4. A toxocology screen was done, but was lost. The child had several episodes of axial myoclonic jerking each day. There was a history of seizures in his father's family. His grandmother's mother, as well as her brother and sister and their respective children, suffered from seizures.

An MRI done at this time revealed extensive symmetrical white matter abnormalities, sparse calcifications near the temporal horns and several cystic areas. No white matter abnormalities of the brain stem or cerebellum were observed. Gray matter was smoother and simpler than normal. Abnormally flat and simple gyri and sulci, thick cortex in the frontal posterior and temporal posterior areas and incomplete opercularization of the Sylvian Fissures were noted. In addition,

the ventricles were enlarged. The physician prescribed 15 mgs Phenobarbital 15 mg bid.

The child was also examined by the family physician in October and November. In November, at 10 months of age, he weighed 17 pounds, 6 ounces, had a fever and no appetite. He did not vomit or have diarrhea. The physician noted that the infant did not hold his head up well, arched his back, had a reddened pharynx, bronchi in the chest and a temperature. Thrush was diagnosed.

The child was taken to the university for a follow up exam in early December. He still had severe spastic quadriplegia, but was able to turn from front to back. At 11 months old, he scored three-to-five months on the Denver Developmental test. The child had no more seizures and controlled on medications. The physician also noted that the boy ate and swallowed well. The head circumference measured 47 cm. The fundi were seen briefly and the pigment mentioned on the previous exams was not observed.

In April 1976, the baby had his third DTP injection, with no reaction. In May 1976, the mother took the boy to a cerebral palsy clinic where she gave a history of the onset of the problem after the second hernia surgery. She mentioned that he was limp following surgery. When further questioned, she stated that while changing the infant's diapers prior to the DTP injections, she found it exceedingly difficult to abduct his legs in order to fit the diaper. This led the physician to believe that there was some spasticity, which perhaps had not been noticed earlier.

Finally, in October 1976, the fourth DTP injection was given to the boy without reaction.

The parents sought the counsel of an attorney in May 1976, because of the child's condition. They felt the boy's impairment was due to the second hernia surgery. After the initial investigation of the surgery and anesthesia care, a complaint was filed 10 years later, August 1986, alleging that the boy's injuries were due to DTP reactions.

The following questions were the basis for the argument on both the plaintiff and the defense sides:

- * Was the high-pitched screaming and inconsolable crying a sign of cerebral insult or irritation from the hernias?
- * Was the upper respiratory infection a contraindication to giving DTP?
- * Should a more thorough neuro exam have been completed prior to giving the DTP after noticing the tilting of the head?
- * Was there a significant reaction to the DTP to warrant withholding further doses?
- * Did the second injection exacerbate symptoms causing further loss of head control, limpness, spasticity, retardation and seizures?

- * Was there a congenital defect that caused the spastic quadriplegia and mental retardation?

Arguments

The plaintiff and defense experts argued over the MRI to explain the neurological deficits. The plaintiff's expert interpreted the MRI to show acute disseminated encephalomyelitis, and the defendant's expert interpreted it as neuronal migration abnormalities dating from the third-to-fifth months of gestation.

The experts also argued over whether unincarcerated hernias are painful to infants and caused the crying, versus the crying causing the bulge of the hernia to be more noticeable.

The plaintiff's expert said the DTP could cause permanent brain damage. He conceded that there are three criteria which must be satisfied in order to establish that DTP caused permanent brain injury in any specific case:

1. The child was neurologically normal prior to the DTP shot.
2. There are no other reasonable medical explanations for the child's neurologic injuries.
3. The child exhibits severe neurologic reactions of encephalopathy within 72 hours or at most, seven days.

The defense, on the other side, brought up the Loveday Decision from England in which the English court ruled as a matter of law that there was insufficient evidence to establish the probability that DTP causes permanent brain damage.

Another argument examined whether there was a significant reaction, within a realistic amount of time, to the first injection to withhold subsequent doses or whether the inconsolable crying and high-pitched screaming were due to other causes since they occurred more than 72 hours following the injections.

Conclusions

Today, the boy is 15 years old and his seizures are controlled by Depakote. However, he is uncommunicative, cannot walk, or care for himself. In addition, the mother has given birth to three more children who are normal. The defense attorneys gave a 50% chance of winning this case with a possible jury award of \$2 million to \$4 million. The case was settled July 1990 for an undisclosed amount of money.

The risk for pertussis infection is greater among infants and the disease may be neurologically devastating. Proper immunization may prevent the disease from occurring, however, it is not without risk. Lawsuits may be filed against you and the manufacturer as a result of reactions to the pertussis vaccine as just shown. Such cases may go on for many years prior to settlement or trial. Following the risk management tips may help to decrease these types of claims, or help your defense if they do occur.

Claim Data

Approximately three serious events occur per million doses of pertussis.² Neurological disorders are the most significant side effect, but are rare compared with the neurological effects of pertussis itself. The three manufacturers of DTP, absorbed, show a dramatic increase in lawsuits filed against them, from one in 1978 to 73 in 1984. The average cost for the manufacturer increased from \$10 million to \$46 million over the same time period.³

Risk Management Tips

- * Inform parents of the risks of the vaccinations along with the consequences of not receiving them. Document this discussion thoroughly in the patient's record and provide a consent form.
- * Perform a complete neurological and delayed developmental exam prior to administering doses of pertussis.
- * Question parents thoroughly for reactions to the first injection, prior to administering subsequent injections.
- * Document the lot number, expiration date and manufacturer of the vaccine administered.
- * Make follow up phone calls to the parents within three days after each dose of pertussis is given. Ask about complications and document the responses.
- * Call and follow up with parents when the immunizations are missed due to illness.
- * Keep old insurance policies and patient records if patients are children or newborns.
- * Read all package inserts on the medications you prescribe or use.
- * Assist in the development of vaccination policies in your hospital's special care nurseries.
- * Check with local health departments regarding reporting requirements for vaccination reactions.

Comments

The 1985 Ad Hoc Report of the American Medical Association states that if DTP encephalopathy exists, it is characterized by an acutely ill child whom the parents will recognize as requiring medical attention. In *Mulder v. Parke-Davis*, 288 Minn. 332, 181 N.W.2d 882 (1970), the Minnesota Supreme Court held that the instruction of a drug manufacturer in its package insert or the Physicians' Desk Reference establishes *prima facie* the standard of care for

physicians in a medical malpractice case. If the physician is proved to have departed from that standard, the departure constitutes negligence unless the physician offers proof excusing his or her departure. Subsequent cases have held that the Mulder rule does not apply if ambiguities in the package insert exist.

According to the 1988 "Redbook" published by the American Academy of Pediatrics, neurological sign or symptom must reasonably occur within 72 hours in order to constitute an absolute contraindication to the vaccine. Recommendations found on Pages 321-322 include the following contraindications:

- * Encephalopathy within seven days (1:140,000), including such manifestations as severe alterations of consciousness and focal neurologic signs. Permanent neurologic deficits occur in approximately one-third of these cases (1:330,000). Studies indicate that encephalopathy associated with DTP is clinically evident within 72 hours after receipt of the vaccine, but prudence justifies considering encephalopathy occurring within seven days of DTP as a contraindication to further doses of pertussis-containing vaccine.
- * A convulsion, with or without fever, occurring within three days (estimated frequency within 48 hours of immunization is 1:1,750). In addition, a child experiencing a convulsion at any time should be evaluated carefully to determine if additional doses of pertussis-containing vaccine should be given.
- * Persistent, inconsolable screaming or crying for three or more hours (1:100) or an unusual, high-pitched cry (1:1,000) within 48 hours.
- * Collapse or shock-like state (hypnotic-hyporesponsive episode) within 48 hours (1:1,750).

- * Temperature of 40.5 degrees C (104.9 degrees F) or greater, unexplained by another cause, within 48 hours (1:330).

- * An immediate allergic reaction to vaccine, severe or anaphylactic in nature, though extremely rare.

The Advisory Committee on Immunization Practice in the Morbidity and Mortality Weekly Review, 1990, 39(4): 405-14, 419-26, recommends that children are appropriately immunized for diphtheria, tetanus toxoid and pertussis when the: 1) first dose is given by three months of age; 2) second dose is given by five months of age; 3) third dose is given by seven months of age; and, 4) fourth dose is given by 19 months of age.

Properly immunizing infants against pertussis may prevent the disease, however reactions as those stated above may occur.

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2. Lewis, et.al. American Journal of Diseases of Children, 142 (March 1988): 283-286.
3. Vohr BR, et.al. Pediatrics, 77 (April 1986): 569-571.
4. Walker AM. Pediatrics, 81 (March 1988): 345-349.
5. Zimmerman B, et.al. Postgraduate Medicine, 82 (October 1987): 225-229, 232.

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WORKMAN'S COMP

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PRIMARY CARRIER

PRIOR AUTHORIZATION

TYPE OF SERVICE CODES

SAME/SIMILAR INDICATOR

PATIENT CHARTS DAY SHEETS

SUPERBILL

CPT PROCEDURE CODES

WAITING LEDGER CARDS

ROOM INSURANCE CARDS

DISABILITY GROUP POLICY NUMBER

PATIENT STATEMENTS RELATIONSHIP TO THE INSURED

APPROVED AMOUNT

APPOINTMENT BOOK EXAMINATION ROOM TICKLER FILES

SELF PAYS MEDICAID ATTENDING PHYSICIAN PPO/HMO

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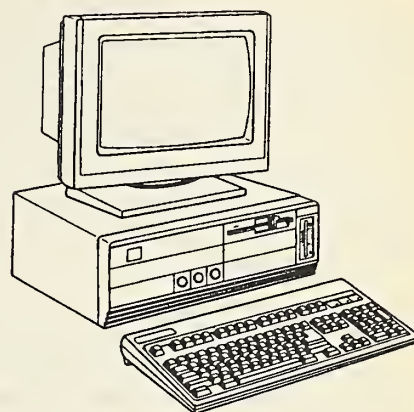
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Mips, Bytes, Megahertz.... Who Cares?

What do you really want from a computer system, and how to find it?

Chris Beagle*



The horror stories are everywhere. Offices that purchased expensive computer systems that either no longer meet the needs of the practice, or even worse, are no longer sold or supported by the dealer.

Computers in your practice are inevitable. One Medicare field representative estimated that as quickly as 1995 government carriers will accept only claims submitted via computer and electronic claims submission.

It is a simple case of economics. Government is searching for ways to stretch the dollars available to Medicare and Medicaid programs. One of the easiest ways to accomplish this goal is to lower the cost of administration, and no single factor can reduce these costs like electronic claims submission.

The new filing requirements that took effect September 1st of this year were a cost reduction measure, and a fore-shadow of things to come. Claims submitted directly by the patients were riddled with errors; consider the difficulty your staff has in completing the forms and you can understand why individuals would have problems. By requiring your staff to file the claim for the patient the agencies will have fewer rejected claims, and as a result lower their administrative costs. You no doubt noticed the lack of consideration for the effect this will have on your administrative costs.

Now consider the fact that the money saved by this measure is minute compared to the potential savings of mandatory electronic claims submission. The only remaining question is how soon will you be required to submit electronically.

So how can you avoid the pitfalls of computer buying without learning a whole new language of Megabytes, Mips, and Megahertz?

It isn't easy, but it is possible.

The first thing you have to do is realize that you and your staff are already the computer experts. You may not under-

stand the jargon and the acronyms that the sales people toss at you, but you are the only people who can answer the really important questions like:

- * What specific tasks do I, and my staff, want the computer system to perform?
- * How easily will any given computer system integrate into the flow of information that exists within your office?

The answers to these questions far outweigh the importance of how fast, how fancy, and how much, any particular computer system happens to be. In fact, definitive answers to these questions provide the basis for the answers to all the other questions for you.

Please notice the inclusion of your staff in the decision making process. The initial success of any computer system is greatly dependent on how the system is received by those expected to operate it. Including the key members of your staff in every aspect of the selection process will ensure that when the system is installed, they feel dedicated to making it work - after all they picked it out.

You also need to consider the make up of your staff; more than one older office worker has chosen to retire rather than be forced to operate a computer. Other people are simply afraid, and therefore unwilling to put forth the effort required to learn a new system.

The point is to start with questions that are centered around your particular office like, "What dirty jobs would we like to turn over to a computer?" Don't worry about whether you think a computer can perform those specific tasks; the computer experts will be more than happy to tell you whether or not their respective systems are able.

Too often people purchasing computer systems start with, "What does it do?"; leaving themselves at the mercy of computer sales people who can easily overwhelm you with the incredible feats their systems can perform. In most

* Mr. Beagle is with Arkansas Express Claims in West Memphis, Arkansas.

cases, however, these feats require too much of your staff's time, making them impractical in the real world.

The truth is that a system's potential capabilities are unimportant. Only the features your staff is committed to using on a day to day basis are important; the other pieces of the program just sit idle after the initial training sessions. The goal is to find the system that handles the day to day jobs in the way that is best suited to your office.

A precious few computer sales people are qualified to determine how well their system is going to integrate into your office. You, and your staff, are the people most qualified to determine this. You are the experts.

Simple Truths About Purchasing A Computer

The most important single factor in purchasing a computer system has nothing to do with what you buy, but rather from whom you buy it. The dealer is the key to the long range success of any computer installation. If you would not hire this person to work in your office, don't purchase a computer system from them. This dealer becomes part of your office staff for the first three to six months that are required for the system to fully integrate into your practice. What do you look for in a dealer?

Does the dealer speak your language?

A medical practice is a unique operation. If the dealer does not have first hand knowledge of the basics of running that operation then this should be a red flag to you. If you find yourself explaining basic terms like secondary carrier, CPT code and charge slip then steer away. If you purchase a system from this kind of dealer you will have to teach them how the office works before they can teach you how to make the system work for your office.

Does the dealer respond quickly, and when promised?

How well a dealer responds to your requests before you purchase a system is a strong indicator of the kind of service you can expect after the sale is made. If it takes three days for the dealer to call you back before the sale, it may not seem that critical. But, after the system is in your office, even one day is frustrating - not to mention expensive.

Does the dealer offer references?

It is a good idea to make the effort to call references. Of course, you will talk to the people who the dealer has screened to make sure they say wonderful things. But, if you ask for the most recent installation, and one two years old you will get a pretty good indication of what to expect in the way of support.

So once you have found the dealers you feel are qualified to help you, what features do you examine to differentiate between software packages?

Electronic Claims Submission

The most important, and probably least understood, feature a system must offer is electronic claims submission. It is important because it will become your link to Medicare, Blue Cross & Blue Shield, and Medicaid payments, and as industry standards evolve, it will most likely become the preferred method for submission to large private carriers.

Most systems offer an electronic claims module of some kind. You can find little comfort in a salesperson's assurances that his system does electronic claims submission. You have to look beyond if it can submit, to how it submits.

Because there is no national standard for electronic claims submission many of the nationally distributed software packages offer electronic claims submission via a clearing house. Clearing houses offer one advantageous feature. They allow you to send electronic claims to a large number of carriers. However, in most situations this is not an economical option.

They make their money by charging a fee for each claim you send. How much you pay per claim is determined by how many claims you submit each month. The per claim fee varies with each clearing house, but generally range from a high of \$1.15 to around .60 cents.

Arkansas Blue Cross & Blue Shield is a leader in electronic claims submission. There are four ways for a provider to submit electronic claims directly to Arkansas Blue Cross & Blue Shield. Computer systems that do not offer electronic claims submission directly to Arkansas Blue Cross & Blue Shield are already outdated.

Arkansas Blue Cross & Blue Shield even offers it's own form of clearing house with a set fee of \$49.00 per month. The other options have no monthly fee and no per claim fee. In the ideal circumstance the Blue Cross & Blue Shield computer will call your computer during the night to collect your claims.

Different means of submitting claims require slightly different equipment and system configurations, but with some technical knowledge and persistence any computer system in the state of Arkansas is capable of electronic claims submission via one of these methods.

There are no other absolutes for choosing a particular software package, but there are some questions that you should ask about each package you are considering that may aid in the selection process:

- * Can the dealer customize the package to the specific needs of your practice?
- * If he can, how much will future changes cost, and how long will it take him to deliver after a request is made? If he can not, make sure that the package generates every report and performs every task you will require now and in the future.
- * Does the package contain a forms generator?

- * If it does, can someone in your office be taught to use it? Small changes in filing requirements can become big headaches if the system can not adapt. If they do not have a forms generator, make sure the publisher of the software actively tracks changes in filing requirements and will update your system in a timely manner when those changes come along.

Does the dealer and/or publisher provide remote support?

Remote support allows the dealer to resolve problems via phone lines and a modem. This prevents the cost and time delays of waiting for the dealer to make a service call. Using one of these packages a technician can take complete control of your system. To the technician, it is just like standing in your office, he has all the diagnostic and system

utilities at his disposal. This kind of support is standard practice in all special markets of the personal computer business.

When you are purchasing a computer system for your office don't get bogged down in the name brands, the technical specifications, and the pipe dream functions that your staff will never make time to realize.

Instead, decide what tasks you want the computer to perform, and look for a dealer that understands the problems you face and how to apply computers to resolve the problems and perform the tasks. The fastest computers, and the best software, are useless if they are purchased from a dealer that is not going to take the time to integrate the system into your office and stay with you to make the necessary changes and solve the little problems that every system eventually develops. Like the old real estate adage, the three most important factors in the success of a computer system are dealer support, dealer support, and dealer support.

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RSNA Scientific Assembly and Annual Meeting. McCormick Place, Chicago, IL. For more information, call Jodi Skrip at (312) 558-1770.

December 3-7

Physicians in Management I, Hyatt Regency Sarasota, FL. Sponsored by the American College of Physician Executives, Tampa, FL. CME credits available. For more information, call, 1-800-562-8088.

December 8

Orthopaedic Update, Marriott City Center, Charlotte, NC. Presented by the Southern Medical Association, Birmingham, AL. CME credits available. For more information, call LaDonna Nail at 1-800-423-4992.

December 8-9

Surviving the 90's, Ocean Reef Club, Key Largo, FL. Presented by the Southern Medical Association. CME credit available. For more information, call LaDonna Nail at 1-800-423-4992.

December 13-14

How To Get Started in Medical Practice, Hyatt Regency, Nashville, TN. Presented by the Southern Medical Association. CME credit available. For more information, call LaDonna Nail at 1-800-423-4992.

December 15-16

How to Get Started in Medical Practice, Ramada Convention Center, Memphis, TN.

January 5-10, 1991

Rheumatology for the Practicing Physician, Keystone Resort, Colorado. Sponsored by the Washington University School of Medicine, St. Louis, MO. Fees to be announced. For more information, contact Cathy Caruso at 1-800-325-9862.

January 18-20

Diagnostic Dilemmas in Cardiology, Hyatt Caribe, Cancun, Mexico. Presented by the Southern Medical Association. CME credit available. For more information, call LaDonna Nail at 1-800-423-4992.

January 10-11

How To Get Started in Medical Practice, Holiday Inn - Busch Gardens, Tampa, FL. Presented by the Southern Medical Association. CME credit available. For more information, call LaDonna Nail at 1-800-423-4992.

January 12-13

How to Get Started in Medical Practice, Omni International Hotel, Miami, FL.

January 24-25

How to Get Started in Medical Practice, University Conference Center, Little Rock, AR.

January 26-27

How to Get Started in Medical Practice, Omni Hotel, Charleston, SC.

February 7-8

How to Get Started in Medical Practice, Park Suites Hotel, Jacksonville, FL.

February 9-10

How to Get Started in Medical Practice, Ramada Hotel Resort, Orlando, FL.

February 20

How to Manage a More Profitable Practice, Orlando, FL. Presented by the Southern Medical Association. CME credit available. For more information, call LaDonna Nail at 1-800-423-4992.

February 21

How to Manage a More Profitable Practice, Sheraton-Brickell Point, Miami, FL.

February 22-23

How to Manage a More Profitable Practice, Crystal Palace, Nassau, Bahamas.

February 21-24

Rhinoplasty. Location and fees to be announced. Sponsored by the Washington University School of Medicine, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862.

**The AMA
Hospital Medical Staff Section
Sixteenth Assembly Meeting
November 29 - December 3, 1990
The Peabody Orlando
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Highlights of the Interim Meeting will include:

- an educational program on Economic Credentialing;
- presentation by the AMA-HMSS Governing Council of reports on medical staff issues including Health Care Cost, Waiver of Confidentiality Upon Application for Reappointment and State Hospital Medical Staff Section (HMSS) Oversight Peer Review Committee;
- recommendation of policy to the House of Delegates on Denial of Payment for Pre-Existing Conditions, Third Party Payors and Patient Care Standards;
- AMA-HMSS Governing Council election for the position of Delegate.

For Information Contact:

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HMSS

Keeping Up

HIV/AIDS - Nursing Issues for the 1990's

Novmeber 15, 8:30 a.m. - 4:15 p.m., First Baptist Church, Jonesboro. Sponsored by the Delta Regional AIDS Education and Training Center, Arkansas State Nurses Association, Arkansas Licensed Practical Nurses Association and RAIN (Regional AIDS Interfaith Network). Fees: \$20.00; \$10.00 students and retirees. For more information, call Eva Reynolds at 686-5000.

HIV/AIDS - Nursing Issues for the 1990's

December 7, 8:30 a.m. - 4:15 p.m., First Presbyterian Church, Monticello. For more information, call Eva Reynolds at 686-5000.

University-Based Perinatal Continuing Education Seminar

December 7, location and time to be announced.
Sponsored by the UAMS College of Medicine and presented by J. Gerald Quirk, M.D.

Panic Disorders: Methods of Management

December 7, 8:00 a.m., Little Rock Hilton Inn.
Sponsored by the UAMS College of Medicine and presented by George Hamilton, M.D. Category I credit available. Fees: \$60.00 physicians; \$40.00 health care professionals; \$25.00 UAMS faculty.

Winter Seminar 1991

January 31 - February 1, 8:00 a.m. - 12:00 noon, Key West, Florida. Presented by the Baptist Medical Center, Medical Affairs Department. Fees: \$250.00 physicians; \$175.00 nurses and allied health professionals. Category I credit available.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

Continuing Medical Education Luncheon, second Friday, 12:30 p.m. AMI Ozark-Quapaw Room. One Category I credit per meeting.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), third Wednesday, 12:30 p.m., Conference Room, Building 1, VAMC

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Faculty Resident Seminar, third Thursday, 12:00 noon, Sturgis Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Building, Room 457
Infectious Disease Conference, second Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Building, Auditorium
Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., 2nd Floor Classroom
Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, 2nd Classroom
Pediatric Research Conference, first Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

Sleep Disorders Case Conference, third and fifth Thursday in November and second and fourth Thursday in December. Lunch provided.
Interdisciplinary AIDS Conference, second Friday, 12:00 noon. LaHarpe Room. Sandwich buffet is served.
Cancer Conference, third Thursday, 12:00 noon, Laboratory Conference Room. Lunch is provided.
Hematology-Oncology Conference, second Thursday, 12:00 noon. Lunch is provided.
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Southwestern Bell/Arkla Room. Refreshments are provided.
Pulmonary Conference, second and fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla Room. Sandwich buffet is served.
Journal Club, every Tuesday, 12:00 noon, Conference Room 1. Lunch is provided.
GYN Surgery Cancer Conference, second Monday, 12:00 noon. Lunch is provided.
Joint Tumor Conference, first Wednesday, 12:00 noon. CARTI Auditorium. Lunch is provided.

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., Conference Room 1

Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lectures and case presentations. A light lunch is provided.

Pathology Conference, third Tuesday, 3:00 p.m., Pathology Library

Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. A light lunch is provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC Oncology Forum, fourth Thursday, 4:00 p.m., UAMS ACRC 2nd Floor Conference Room, 1.5 credits

Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B

Anesthesia Morbidity and Mortality Conference, second and fourth Tuesdays, 6:45 a.m.; first, third and fifth Thursdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B

CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy

Cardiothoracic Surgery Conference, first Thursday, 8:00 a.m., location varies

Child Psychiatry Clinical Case Conference/Research Review, most Fridays, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room

Dermatopathology Conference, Tuesdays, 8:00 a.m., UAMS Education Building, Room G/108 A&B

Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Building, Room G/110A&B

Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Building, Room G/110A&B

Emergency Medicine Grand Rounds 1, third Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B

Emergency Medicine Grand Rounds 2, third Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B

GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology Conference Room, #M1/293.

Hematology Fellow's Forum, second, third, and fourth Fridays, 8:15 a.m., ACRC Betsy Blass Conference Room

Hematology/Oncology Clinical Problems Conference, Thursdays, 8:15 a.m., LRVA Pathology Conference Room

Interdisciplinary Gynecologic Cancer Conference, Fridays, 12:30 p.m., UAMS Education Building, Room G106 A&B

Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., St. Vincent Infirmary Education Bldg., Arkla/Bell Room

Little Rock Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC Conference Room three times per month, CARTI Auditorium one time per month

Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Building, Room G/131A&B

Medicine Research Conference, three Wednesdays per month, 4:30 p.m. Shorey Building, Room 3S06

Neurology Clinical Case Conference, Thursdays, 8:00 a.m. VAMC-LR Room 2D109

Neuropathology Conference, Thursdays, 10:00 p.m. UAMS Morgue

Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33

Ob/Gyn Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Building, Room G/131B

Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, Room 3/150, 2 credit hours

Orthopaedic Basic Science Conference, occasional Tuesdays, 11:00 a.m., UAMS Education Bldg., Room B/135

Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Building, Room B/135, 1.5 credit hours

Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Building, Room B/135

Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Building, Room B/135

Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue

Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Shorey Auditorium

Surgery Basic Sciences Conference, first Saturday, 7:30 a.m., ACRC 2nd floor conference room

Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room

Surgery Morbidity and Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room

Surgery Resident Case Conference, second, third, fourth, fifth Saturday, 7:30 a.m., ACRC 2nd floor conference room

Surgery Staff/Clinical Case Conference, alternating Tuesdays, 7:00 a.m., UAMS Education Building, Room G/141

Surgery Vascular/Radiology Conference, Tuesdays, 5:00 p.m., VAMC-LR Radiology Conference Room

Surgery Vascular Teaching Conference, Thursdays, 3:00 p.m., VAMC-LR Radiology Conference Room.

Urology Basic Sciences Conference, second Wednesday, 5:00 p.m., UAMS Education Building, Room G/106A&B

Urology Clinical Didactic Conference, third Tuesday, 5:00 p.m., UAMS Shorey Bldg., Room 2S08

Urology Core Conference, once or twice monthly, 5:00 p.m., UAMS Shorey Bldg., Room 2S08

Urology Grand Rounds, second and fourth Tuesday, 5:00 p.m., VAMC-LR (4D)

Urology Morbidity and Mortality Conference, last Wednesday, 5:00 p.m., UAMS Shorey Bldg., Room 2S08

Urology Teaching Conference, once or twice monthly, 5:00 p.m., UAMS Shorey Bldg., Room 2S08

Uro-Radiology Conference (Urologic Imaging), once monthly, 5:00 p.m., UAMS Shorey Bldg., Room 2S08

VA Chest Conference (combined Surgical/Medical Chest Conference), alternating Mondays, 12:15 p.m., VAMC-LR, Room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine Conference Room, Room 1D173
VA Geriatric/Gerontology Research Conference, Wednesdays, 3:15 p.m., VAMC-LR, Room 1E123
VA Hematopathology Conference, Wednesdays, 3:00 p.m., VAMC-LR Pathology Conference Room
VA Lung Cancer Conference (combined Medical/Surgical Lung Cancer Conference), Tuesdays, 3:00 p.m., VAMC-LR, Room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Building 68
VA Medicine-Pathology Conference, Tuesday, 2:00 p.m., VAMC-LR, Room 2D109
VA Medicine Service Resident's Clinical Case Conference, Fridays, 12:00 noon, VAMC-LR, Room 2A109
VA Physical Medicine and Rehab Grand Rounds, fourth Friday, 11:00 a.m., VAMC-NLR Building 68, Room 118 or Arkansas Rehab Institute
VA Psychological Assessment Conference, Tuesdays, 3:00 p.m., VAMC-LR & NLR Psychology Department, 1.5 credit hours
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, Room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine Conference, Thursdays, 8:00 a.m., VAMC-NLR Building 68, Room 118
VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology Conference Room

EL DORADO - AHEC

Behavioral Sciences Conference, first and fourth Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, second Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second and fourth Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, fourth Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, first, second and third Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

Behavioral Sciences Conference, third Wednesday, 12:00 noon, Washington Regional Medical Center
City Hospital Staff Medical Meeting, second Friday, 12:00 noon, Fayetteville City Hospital
Family Medicine Conference, first, third, fourth Thursday; fourth Wednesday; second Thursday (odd months) AHEC-NW, 241 W. Spring, Fayetteville
Interesting Case Conference, first and third Friday, 12:00 noon, Fayetteville City Hospital
Medicine Conference, first and third Tuesday, 12:00 noon, Washington Regional Medical Center
OB/GYN Conference, December 13, 12:00 noon, AHEC Conference Room
Pediatric Conference, second Wednesday, 12:00 noon, Washington Regional Medical Center
Radiology Conferenc, December 5, 12:00 noon, Washington Regional Medical Center
Nutrition Conference, November 7, 12:00 noon, Washington Regional Medical Center
Surgery Conference, second Tuesday, 12:00 noon, Washington Regional Medical Center Fulbright Board Room

FORT SMITH - AHEC

Internal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center
Pediatric Cardiology, November 21, 12:00 noon, Sparks Regional Medical Center, 7th floor dining room
Issues in Ventilator Weaning, November 28, 12:00 noon, Sparks Regional Medical Center, 7th floor dining room

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first and third Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.
Chest Conference, second Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided
Craighead/Poinsett Medical Society, first Tuesday, 7:00 p.m. Jonesboro Country Club
Eaker AFB CME Conference, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria
Independence County Medical Society, second Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, fourth and fifth Tuesday, 12:00 noon, St. Bernards Dietary Conference Room. Lunch provided.
Jackson County Medical Society, third Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, third Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, second Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neuroradiology Conference, third Friday, 12:00 noon, St. Bernards Dietary Conference Room. Lunch provided.
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Pocahontas CME Conference, third Wednesday, 12:00 noon and 7:30 p.m., Randolph County Medical Center Boardroom
Tumor Conference, second Thursday, fourth Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided
Walnut Ridge CME Conference, third and last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
White River CME Conference, third Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

PINE BLUFF-AHEC

Behavioral Science Conference, first and third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second and fourth Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, first and fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, second and fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second and fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Neuro-Radiology Conference, first and third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

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| A. Publication No. 00041858. | A. Total No. copies (net press run): | 3,246 | 3,328 |
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Ken Lamastus, CAE

New Members

BENTON COUNTY

Hales, David C., Internal Medicine, Rogers. Born August 6, 1960, Leland, MS. Medical education, University of Mississippi, Jackson, 1987. Internship/residency, University of Texas Southwestern Medical Center, Dallas, 1990. Board eligible.

CRAIGHEAD COUNTY

Camp, Michael J., Cardiology/Internal Medicine, Jonesboro. Born December 8, 1959, Grand Forks, ND. Medical education, East Tennessee State University, Johnson, TN, 1986. Internship/residency, ETSU, 1990. Board certified.

JEFFERSON COUNTY

McFarland, Mike S., Ophthalmology, Pine Bluff. Born October 9, 1950, St. Louis, MO. Medical education, UAMS, 1977. Internship/residency, Louisiana State University Medical School, 1981. Practice experience, 10 years. Board certified.

PULASKI COUNTY

Cash, Darlene K., Hematology/Oncology, Little Rock. Born September 1, 1951, Portsmouth, VA. Medical education, University of Tennessee, Memphis, 1976. Internship/residency, Methodist Hospital, Memphis, TN, 1979. Fellowship, UAMS, 1983. Practice experience, 7 years.

Kane Jr., Francis J., Psychiatry, Little Rock. Born March 29, 1929, New York City, NY. Medical education, New York Medical College, New York City, 1953. Internship, Mercy Hospital, Wilkes Barre, Pennsylvania, 1954. Residency, New York Medical College, New York City, 1957; Institute of Living, Hartford, CT, 1960. Practice experience, 30 years. Board certified.

SEBASTIAN COUNTY

Peluso, Frank E., DO, Fort Smith. Born February 5, 1949, Queens, New York. Medical education, Philadelphia College of Osteopathic Medicine, 1981. Internship/residency, Brooke Army Medical Center, Ft. Sam Houston, TX. Practice experience, nine years. Board certified.

Trent, Judy H., Family Practice, Fort Smith. Born November 6, 1953, Woodward, OK. Medical education, Oklahoma State University, College of Osteopathic Medicine, Tulsa, 1980. Internship, Flint Osteopathic Hospital, Flint, MI, 1981. Practice experience, 10 years. Board certified.

WASHINGTON COUNTY

Whiteley, Andre B., Radiology/Oncology, Springdale. Born December 13, 1941, Tulsa, OK. Medical education, University of Colorado School of Medicine, Denver, CO, 1978. Internship, Wilford Hall Medical Center, San Antonio, TX, 1979. Residency, University of Texas Health Science Center. Board certified.

YELL COUNTY

Richison, George C., Family Practice, Danville. Born April 16, 1959, Big Springs, TX. Medical education, UAMS, 1986. Internship/residency, Washington Regional Medical Center, Fayetteville, 1989. Board certified.

RESIDENTS

Neal, Linda A. Born November 18, 1953, Poplar Bluff, MO. Medical education, UAMS, 1988. Internship/residency, UAMS.

STUDENTS

Raymond, Paul H.
Shaw, Robert H.

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References:

1. Data on file, G.D. Searle & Co.
2. 1988 Joint National Committee: The 1988 report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med* 1988;148:1023-1038.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol clearance may occur with combined use. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration.

Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, increased urination, spotty menstruation, impotence.

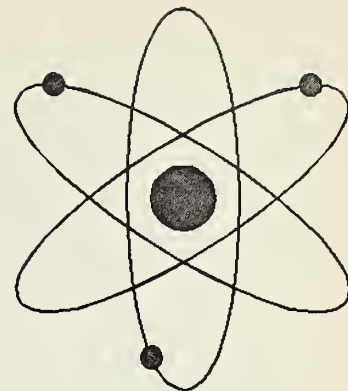
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Radiological Case of the Month



Janis Allison, M.D.
David L. Harshfield, M.D.
Steven R. Nokes, M.D.



Figure 1. PA chest view.



Figure 2. Lateral chest view.

History:

This 60-year-old man has had a productive cough and progressive dyspnea for several years. He also complains of blue fingers, especially when exposed to cold. On examination, his fingers and toes are clubbed and his skin is shiny and taut.

The editors wish to thank Dr. Allison for her contribution to this month's feature.

Scleroderma

Findings:

Bilateral coarse reticular densities (honeycomb lung) are identified mainly involving the lower lungs. An air-filled esophagus is seen on both the PA and lateral view.

Discussion:

The differential diagnosis for honeycomb lung is extensive including rheumatoid lung, scleroderma, dermatomyositis, drug sensitivity (nitrofurantoin, busulfan, bleomycin), ankylosing spondylitis, silicosis, asbestosis, berylliosis, chemical inhalation, allergic alveolitis (farmer's lung), oxygen toxicity, chronic aspiration, sarcoidosis, eosinophilic granuloma, usual interstitial pneumonitis, desquamative interstitial pneumonitis, tuberous sclerosis, lymphangiomyomatosis, and neurofibromatosis (very rare).¹ The dilated air-filled esophagus helps to narrow the differential to scleroderma.

Scleroderma (progressive systemic sclerosis) is a collagen-vascular disease which affects many organ systems. Most patient have soft tissue involvement with Raynaud's phenomenon (60%), skin thickening progressing to shiny taut skin, soft tissue atrophy, subcutaneous calcification, and myopathy or myositis. Joint involvement may also be present.²

Esophageal involvement is present in 50% of cases with dilatation, atonicity, poor or absent peristalsis and free gastroesophageal reflux through a widely open gastroesophageal junction. Seventy-five percent of the time the small bowel and colon are hypotonic and have pseudosacculations.²

Cardiomegaly is present in 30% of cases due to myocardial and/or pericardial involvement. Cor pulmonale may develop secondary to the interstitial lung disease.²

Lung involvement is present in 10-25% of cases and has a tendency for a basal distribution. The early phases of scleroderma may produce patchy air space consolidations followed by the development of a fine reticular interstitial pattern. This process is gradually replaced by fibrosis which progresses to a honeycomb pattern. Aspiration pneumonitis secondary to gastroesophageal reflux may play a role in the pathogenesis of the lung disease.¹

References

1. Reed JC. Chest radiology: Plain film patterns and differential diagnoses. Year Book Medical Publishers, Inc., 195-198, 1987.
2. Chapman S, Nakielny R. Aids to radiological differential diagnosis. Bailliere Tindall, 335-336, 1984.

Prepared by: Janis Allison, M.D., chief resident of the radiology department at the University of Arkansas for Medical Sciences, Little Rock.

Editor: David L. Harshfield, M.D. is chief of the radiology service at the Veterans Administration Hospital in Little Rock.

Editor: Steven R. Nokes, M.D. is in private practice and is affiliated with Radiology Consultants in Little Rock.

Beginning this month, the Journal of the Arkansas Medical Society will feature a Radiological Case of the Month. David Harshfield, M.D. and Steven Nokes, M.D. will be editing the case each month. The cases will be prepared by various physicians and submitted to Dr. Harshfield and/or Dr. Nokes. If you are interested in submitting an original case, please contact the Society office at 224-8967 or 1-800-542-1058. We hope that you will enjoy this new feature.

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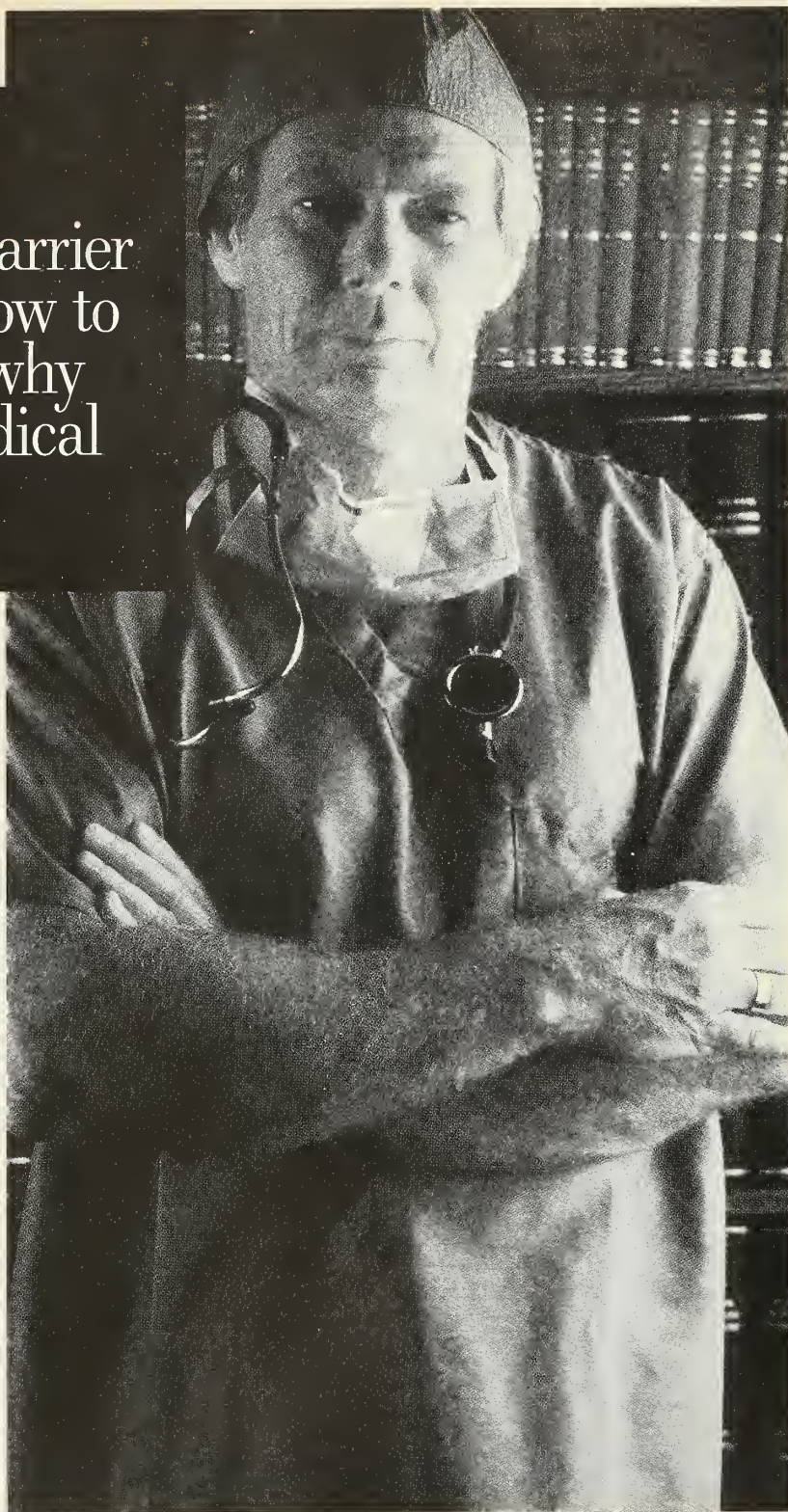
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AMS Newsmakers

James V. Flack, M.D., who has practiced family medicine in Little Rock for 27 years, has been appointed senior vice president for medical affairs at St. Vincent Infirmary Medical Center.

Robert H. Langston, M.D. and Mrs. Langston, of Harrison, recently presented the North Arkansas Community College Foundation with a check for \$15,000 to establish a scholarship in memory of William C. Langston, M.D. and Blanche Peacock Langston.

Moulton Eye Clinic, in Fort Smith, is celebrating its 100th anniversary in the field of Ophthalmology with an open house at the Old Fort Museum in Fort Smith. Herbert Moulton, M.D., Everett C. Moulton, M.D., Everett C. Moulton Jr., M.D., and Everett C. Moulton III, M.D. represent four generations in a direct line practicing Ophthalmology in the same location.

Zena Penn has been named the recipient of the 1990 Pulaski County Medical Society's freshman medical student scholarship. The scholarship is in the amount of \$5,400. The scholarship was presented in honor of long time member J. Edgar Easley, M.D., a former PCMS president.

Graham Reid, M.D., a native of Sheridan, has recently joined the medical staff at Charter Hospital of Little Rock. Dr. Reid will be assuming the role of medical director of outpatient services.

William G. Swindell, M.D., of Rogers Diagnostic Clinic, has been elected to Fellowship status with the American College of Physicians. Fellows of the College are distinguished for their continued pursuit of education and excellence in their medical specialties.

John Wells, M.D., clinical investigator with the Southwest Oncology Group, received a Sustained Performance Award from the group for his continued high accrual of patients to its cancer clinical trials.

Paul I. Wells, M.D., of the Western Arkansas Ear, Nose and Throat Clinic in Fort Smith, has been elected chairman-elect of the Board of Governors of the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS).

In Memoriam

H. Blake Crow, M.D.

H. Blake Crow, M.D., of Prescott, died Thursday, September 27, 1990. He was 63.

Dr. Crow was a served as a member of the House of Delegates of the Arkansas Medical Society. He was a veteran of World War II.

Dr. Crow is survived by his wife, Nancy Crow; a son, Steven Cummings Crow of Prescott; a daughter, Pamela Blake Crow of Little Rock; and two grandchildren.



Physician's Recognition Award

The Physician's Recognition Award is awarded each month to physicians who have completed acceptable programs of continuing medical education. The recipients for the month of September are:

John L. Chapin	Conway
George G. Graham	Little Rock
Jerome H. Luker	Dardanelle
Fernando Padilla	Little Rock
Carl J. Raque	Little Rock
Douglas F. Smart	Little Rock
Ting-Chao Wong	Little Rock

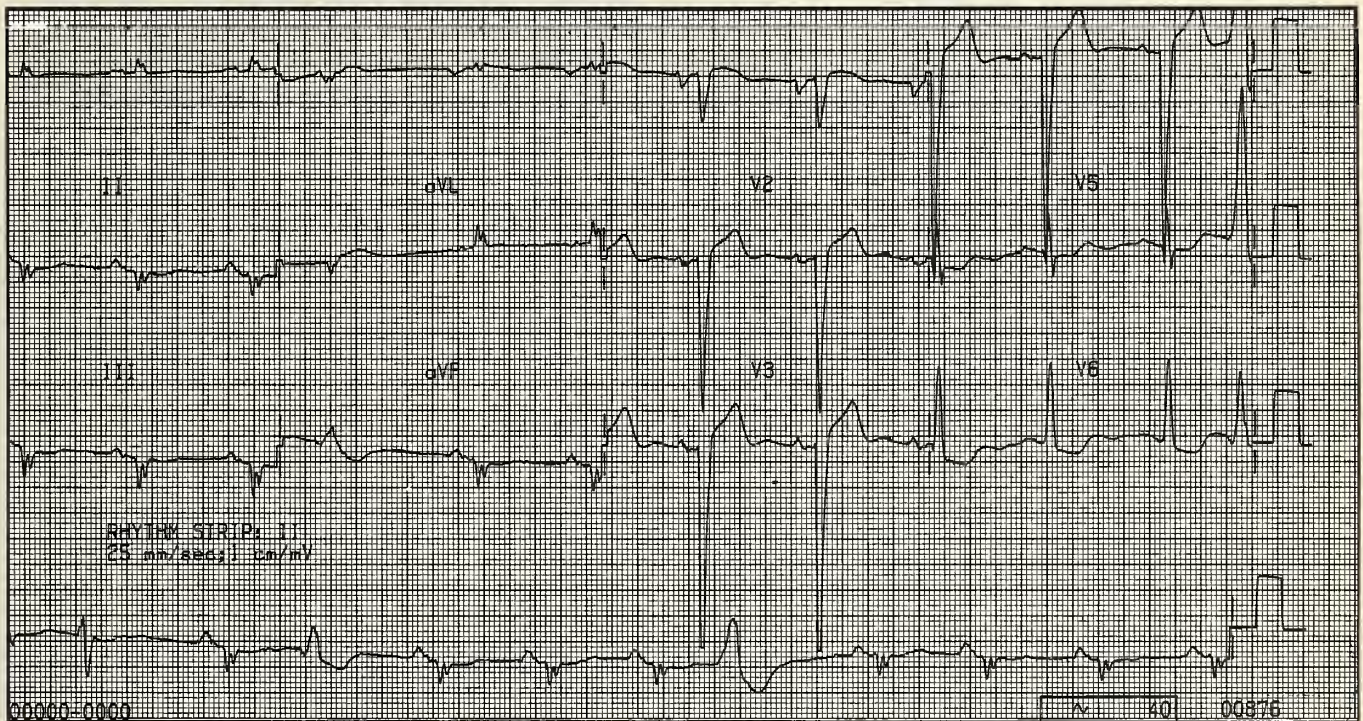
ELECTROCARDIOGRAM of the MONTH



William C. Furlow, M.D.
John W. Watson, M.D.

CLINICAL HISTORY:

P.N. is a 65-year-old woman who presented to the hospital because of crushing substernal chest pain of two hours duration which was associated with intense diaphoresis. Her past history was positive for strokes and hypertension. Her cardiovascular examination revealed hypertension, pulmonary crackles, an S_3 gallop, and a murmur of mitral regurgitation. What do you think of her electrocardiogram?



DISCUSSION:

Sinus rhythm is noted. Classic changes are present for left atrial and left ventricular hypertrophy. The trace suggests the presence of past inferior and septal infarctions. Old electrocardiograms as well as sequential traces would be of great value for evident reasons.

The editor wishes to thank Dr. Furlow of Conway for his contribution to this month's featured electrocardiogram.

Medicine in the News

Health Care Access Foundation Update

As of September 1990, the Arkansas Health Care Access Foundation has provided free medical services to 1,924 medically indigent persons.

The program has 1,483 volunteer health care providers including medical doctors, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.

History of Arkansas Medicine

The History of Medicine Associates of the UAMS Library, with assistance from the Arkansas Endowment for the Humanities, has recently published *Contributions to Arkansas Medical History*. The papers included are the winners of the first five History of Medicine Associates Research Awards. Each of the papers provide information about a different aspect of Arkansas health care.

Copies of the book are available, prepaid only, from:

History of Medicine Associates
c/o Special Collections
UAMS Library, Slot 586
4301 West Markham
Little Rock, AR 72205-7186

The cost of the book is \$15.00 plus a \$2.00 postage and handling fee. There is a special price for associate members.

The History of Medicine Associates is a support group for the Special Collections Division of the UAMS Library which includes historical books, photographs, and archival materials.

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Lyme Disease Continues to Spread in Arkansas

Recent data from Centers for Disease Control show that Lyme Disease, caused by the spirochete *Borrelia burgordferi*, has been diagnosed in most states including Arkansas.

As birds, animals and people move between infected areas, Lyme Disease is being diagnosed at an increased rate. In the United States, incidence in humans has tripled in the past five years and the incidence in domestic animals, including dogs, may be up to 10 times that found in humans. Because of the animal reservoir threat, a new vaccine for prevention of Lyme Disease in dogs has been developed.

Various species of ticks are known to be carriers for this disease. The prevention of ticks on your dog is the first line of defense.

In Arkansas at the present time, there are few animals or people affected with this health debilitating disease. However, if the present trend continues as it has in other states, we can expect an increase of Lyme Disease in Arkansas.

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MANUSCRIPT STYLE

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A Good School Health Program

Sam L. Shultz, M.D.*

The public school system can always be counted on to excite interest at election time, with federal, state, and local candidates pledging support and promising change. However, the matter of school health often does not get close attention. As experienced pediatricians and family practitioners know, if children are not healthy, they do not learn well. A good school health program involves more than hiring a nurse to check immunizations and examine school children for head lice. It requires insightful planning by the medical and nursing community.

Rogers and Young (1984) have stated that the major causes of disability in schoolage children are not strictly medical. They include accidental and non-accidental trauma, substance abuse, learning disorders, dropouts, and teen pregnancy. Some, if not all of these problems, could be prevented by a program which stresses healthy lifestyles.

The above concerns are no surprise to Arkansas physicians. Our teen pregnancy and teen suicide statistics are well known. Motor vehicle accidents, bicycle injuries (and, yes, still numerous ATV 3-wheeler injuries) make up a significant part of our emergency room practice. With regard to substance abuse, Hardin et al (1990) at Arkansas Children's Hospital found an 18% incidence of alcohol abuse in 11-14 year olds. The same study demonstrated increased tobacco usage in this age group, especially smokeless. Twenty percent of the boys in this group chewed and dipped, with 20% of the users exhibiting symptoms of dependency. Arkansas Division of Drug Abuse and Alcohol statistics indicate that teenage alcoholism is equally as prevalent in rural as in urban areas.

It must be remembered that school health programs are an integral part of the community's total child health program, and should not duplicate services already available in the community. Ideally, school health programs should focus on those areas which affect learning and academic performance. Physicians should be involved in planning activities which are most needed in their community. They are experts on the health status and concerns of their pediatric population, as well as available resources.

Programs which are continued because of local tradition or legislative mandate may deplete the resources needed to screen for such non-medical problems as those mentioned earlier. The medical, nursing, and administrative talents are therefore freed to learning. Management in the community or referral to a subspecialist to tertiary center can be accomplished, with the goal of enhancing not only the student's present health status, but also his long-term health practices.

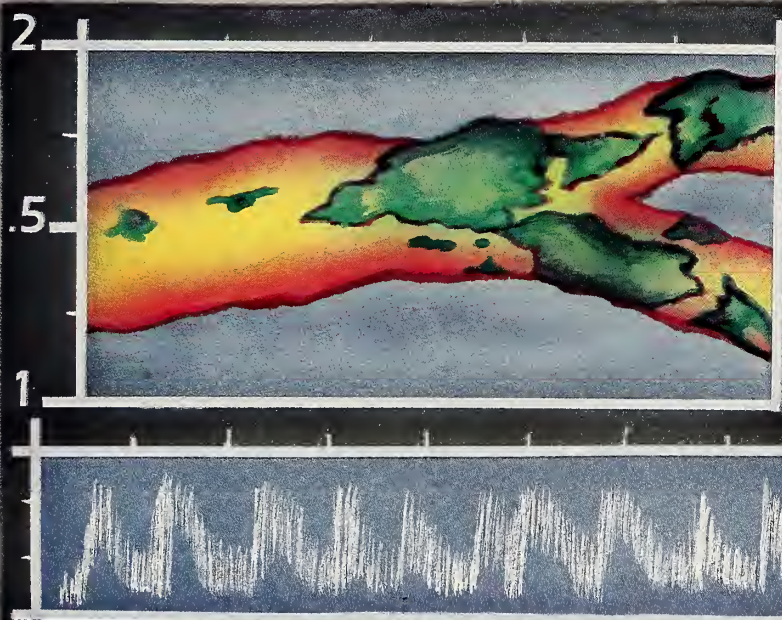
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Specialized Ambulatory Dementia Clinic

Arkansas: Diagnostic & Treatment Services for Patients and Families

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Dementia

Dementia constitutes a major public health problem, with prevalence estimates reported to reach as high as 20% among persons age 65 in various community surveys.¹ Alzheimer's disease is the most publicly known of the dementing syndromes; however, dementia is a symptom complex that may occur in over 60 disorders that encompass a broad spectrum of neurologic, medical, and psychiatric conditions. Because of the potentially treatable and reversible causes of this syndrome, a comprehensive and expert diagnostic work-up is advocated for accurate diagnostic differentiation and informed case management in geriatrics.

A particularly effective model for geriatric evaluation is the multidisciplinary approach.² Among its benefits are increasing diagnostic accuracy, particularly in cases of suspected dementia, decreasing excessive use of drug therapy, and increasing the likelihood of appropriate institutional placement.³ Since most patients suspected of dementia are elderly and outpatients, there has been a developing trend to apply the interdisciplinary model within outpatient ambulatory clinics.⁴ Clinics of this sort are an accessible resource for families as well as professional agencies and community-based physicians and provide comprehensive medical-neurological evaluations and other interdisciplinary assessments. Equally critical to their mission is sound education and management of the patient and family members.

The current report provides a description of an established outpatient dementia clinic at the University Hospital in Little Rock, Arkansas. Its philosophy, goals, staffing patterns, diagnostic practices as well as educational and management strategies are reviewed.

Center for Alzheimer's Disease and Related Disorders (CADRD)

The Center for Alzheimer's Disease and Related Disorders (CADRD) at the University for Medical Sciences was created to provide comprehensive diagnostic evaluations, treatment and follow-up of older patients with presumptive diagnosis of a dementing disorder. The CADRD was founded on the philosophy that dementia is a multifaceted phenomenon with biological, psychological, and social aspects affecting both the patient and the family. The goals of this program are three-fold: (1) identify treatable and potentially reversible disorders resulting in a dementing syndrome; (2) improve the quality of care for the cognitively-impaired person; and (3) lessen the burden of caregivers by providing education, counseling and supportive services.

The CADRD staff is comprised of an interdisciplinary core team consisting of a board certified geriatrician, psychiatrist, clinical neuropsychologist and clinical nurse specialists with additional consulting staff in social work, speech pathology, pharmacy, and dietetics. Trainees have included medical, nursing and pharmacy students, medical residents, geriatric fellows, pre-doctoral psychology interns, and pastoral counseling interns. Although originally operated one morning a week, increased demand and more frequent follow-up of patients and families necessitated an expansion to three days per week.

Preliminary Diagnostic Review Process

Referrals to this clinic come from professionals, families, or, occasionally, by self-referral. Services begin at the initial phone contact as concerned and sometimes very troubled family members often make the first contact and require immediate educative-supportive counseling. A guiding principle of this clinic is to provide not only skilled and competent professional practice, but also an empathic environment in which the emotional and psychosocial needs of

* Affiliated with the University of Arkansas for Medical Sciences in Little Rock.

** Affiliated with John L. McClellan Memorial Veterans Medical Center and UAMS in Little Rock.

patients and their families may be uncovered and addressed.

After the initial phone contact, a packet of materials is sent to the family describing the evaluation process and requesting the primary caregiver and/or patient complete a health questionnaire. The mailed questionnaire elicits extensive information on current health status and behavior including: diet, exercise, motor and spatial coordination, assistive devices for ambulation, falls, sleep patterns, alcohol and tobacco use, health resources utilized, etc. A functional assessment profile is obtained which covers activities of daily living such as dressing, feeding, and toileting abilities as well as instrumental activities of daily living including ability to monitor own medications and manage finances.

At the first face-to-face clinic appointment the diagnostic assessment of the patient continues with objective mental status examination utilizing dementia screening instruments such as the Mini-Mental State Examination⁵ and the Neurobehavioral Cognitive Status Examination.⁶ In addition, the geriatrician conducts physical and neurological evaluations, and obtains a complete medical history of the patient with participation from family members and/or significant others. A Hachinski Score⁷, assessing possible vascular etiology, and objective ratings of depression are obtained as part of the medical examination to assist in differential diagnosis. Additionally, the clinical nurse specialist, psychiatrist and neuropsychologist conduct interviews with the patient and family members to chart the course of cognitive, emotional, behavioral, and functional decline. Particular psychiatric difficulties are brought to the attention of both the psychiatrist and neuropsychologist for diagnostic and management consideration. Caregiver distress, often seen in this population, is carefully assessed by the clinical nurse specialist and/or neuropsychologist with immediate intervention provided as needed. Referrals for needed community services, dietary information, and the like are addressed frequently during this first visit by the clinical nurse specialist or consulting staff.

Subsequent to collection of the preliminary assessment data, which is obtained by essentially all team members in an overlapping manner, a composite picture is painted of the patient and family. At this time team members contribute their expertise and insights to determine an appropriate provisional diagnosis and an individualized treatment plan is formulated. Not infrequently further laboratory studies are needed which traditionally includes complete blood count, erythrocyte sedimentation rate, SMA-12 chemistry battery, triiodothyronine (T3RIA), thyroxine (T4-RIA), thyroid stimulating hormone (TSH), venereal research test for syphilis (VDRL), serum B12 and folate levels. In addition, further neurodiagnostic studies such as magnetic resonance imaging and comprehensive neuropsychological testing are ordered.

Before departing the clinic, the patient and family are provided initial feedback by the physician and other pertinent staff (e.g., neuropsychologist), with the clinical nurse specialist providing written and verbal instructions of our

provisional findings and recommendations, educational materials, information on available community resources, and a follow-up appointment time some two to four weeks later. Families are advised to contact us at any point in this interval, if necessary, for crisis intervention. The CADRD geriatrician subsequently communicates with the family's local physician, the referral source, or any community agencies regarding any medical or health care issues, as is prudent for continuity of care.

Diagnostic Review and Education Counseling

At the second evaluation session diagnostic impressions are more firmly established and follow-up family education and counseling are conducted. There is also an update on any changes in the patient's functional status, behavioral status, or positive responses to treatment interventions (e.g., medications, altered caregiver approaches) as well as changes in caregiver burden. Any repeated neuropsychological tests are also reviewed. These various components of the clinical data base are included in in-depth discussion of the probable type of dementia, complicating factors, severity, behavioral manifestations, and appropriate management techniques.

The diagnosis of dementia is determined on the basis of data obtained from the interdisciplinary team data gathering procedure outlined above. This involves ruling out any secondary etiology which could cause cognitive decline. Previously, it has been well established that dementing conditions may be reversible or irreversible, and comprehensive diagnostic procedures are crucial to insure that reversible causes of dementia are ruled out. The National Institute on Aging Task Force has published an exhaustive list of reversible causes of dementia including the following categories: pseudodementia (depression), intoxication (therapeutic and recreational drugs), metabolic-endocrine derangements, brain disorders (stroke, tumors), cardiopulmonary disorders (congestive heart failure), deficiency states (vitamin B12, folate), and other miscellaneous causes (fecal impaction, sensory deprivation).⁸ Each patient's assessment data are reviewed carefully to determine the presence of any of the potentially reversible causes of cognitive impairment. Resulting irreversible dementias such as Dementia of the Alzheimer's type (DAT), Multi-Infarct Dementia (MID), and Mixed Dementia (presence of both DAT and MID) are then made in accordance with both DSM-III(R) and NINCDS-ADRDA⁹ inclusionary and exclusionary criteria.

Of course, in addition to conducting the diagnostic process of the patient, assisting family members cope with the patient's behavioral and emotional changes as well as their own emotional reactions is a central function of the clinic. There is a "working through" of grief, family conflicts, and a variety of apprehensions and concerns pertaining to causes, prognosis, safety, management strategies, mental competency and placement decisions. These issues have both immediate and long-term effects and require continuity of care. Follow-up care is typically arranged at six month to one year intervals, or more frequent if necessary, particularly

in those cases with definite family crises, caregiver distress, or significant psychiatric disturbances. Prior to the next scheduled appointment, a follow-up telephone call is made by the nurse to assess adequacy of resources, caregiver coping and current patient status.

Discussion

Identification of the health needs of the rapidly growing older segment of our society predominantly falls in the hands of the primary care physician whose practice is becoming increasingly geriatric.¹⁰ Primary care of the elderly involves increasingly diverse medical and psychosocial interventions including nursing home care placement, ethical and guardianship decisions, and family caretaking stress to name just a few. In light of this, medical management of an older patient, especially one suspected of having a dementing disorder, and supportive intervention with the family care providers can exceed the available resources in primary care.

The growing number of specialized geriatric assessment clinics throughout the United States provide comprehensive diagnostic and ongoing treatment services to the elderly and to their family caregivers. Such clinics are designed to address the specialized needs of the elderly with suspected dementing illness. Cognitive or memory decline, emotional-behavioral disruption, or declining adaptive living skills, are problem areas which this clinic is designed and equipped especially to evaluate and treat. In addition, family caregivers faced with increasing dependency of an impaired older family member are provided with ongoing supportive and educative services to assist them in coping with their care providing responsibilities. It is hoped that such specialized outpatient geriatric clinics provide a valuable community resource to assist in meeting the growing medical and psychosocial needs of our aging society.

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The Workplace

A Health Services Survey in Arkansas

Mary Ann Coleman, B.S.*

Paul Roundtree, M.D.**

Mona Ray Fields, Ed.D., R.N.***

Abstract

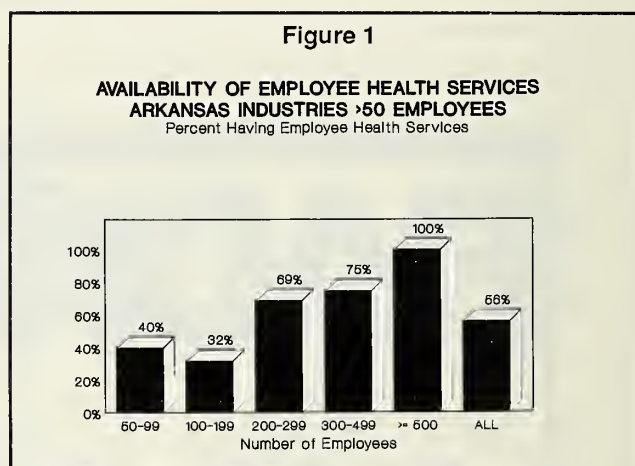
In an attempt to characterize the status of employee health services (EHS) in Arkansas, a workplace health services survey was developed. Questions were asked regarding availability of employee health services, training and background of the director's of these services, numbers and types of personnel working in the area, record keeping and areas of interest for future training. Fifty-six percent of the 75 manufacturers responding reported having employee health services. Most of these EHS were directed by safety personnel (36%), registered nurses (24%), or licensed practical nurses (24%). physicians directed only 7% of the programs, while employees with no special training directed 10% of the programs. Our study indicated a need for expansion of formal training programs for Arkansas physicians, nurses and other health professionals in the field of Occupational Health.

Scope of the Problem

There are approximately 107 million workers over the age of 16 in the U.S. who are employed in over six million different work sites.¹ More than 91% of those who are able to work outside the home do so for some portion of their lifetime.² In Arkansas, as well as nationally, people are employed in diverse industries that range from one to thousands of employees, i.e., manufacturing, service agriculture, and high technology industries. Although some industries

such as agriculture are noted for the high degree of health hazards associated with their work site, more are free of occupational health and safety hazards.

Since the enactment of the first workman's compensation laws in 1911, the responsibility for injuries and illness in the workplace has been placed in the employer. More recently the Occupational Safety and Health Act of 1970 and



the Hazard Communication Act have served to place an even greater emphasis on the responsibility of the employer to the employee in safety and health matters. Congress recently passed legislation requiring employers to inform employees of potentially hazardous exposures at the worksite. Along with expanded government regulations there has been a proliferation of environmental and toxicologic information reaching workers via the news media. Today's workers are more aware of the possibility of illness following exposure to chemicals and other hazards in the workplace environment.

Occupational physicians and nurses were first employed by industry to address these needs and reduce liability costs. As it became evident that the solution was often preventive rather than curative, the skills of industrial hygienists and

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occupational safety practitioners were sought.³ Today well organized, well staffed, full-time Occupational health programs provide medical, nursing, engineering, environmental, radiologic, physiologic, and psychologic services. Such comprehensive occupational health programs include (1) environmental control of health and safety hazards at the workplace and (2) primary, secondary and tertiary health

the baccalaureate nursing programs in the state.⁶ The results indicated a need to expand the material relating to occupational and environmental health in all of the state's nursing programs in order to adequately prepare nurses to work in occupational health care.

In the fall of 1990, a new masters degree program for training occupation health professional was initiated at the University of Arkansas for Medical Sciences. Within the next few years, this program will begin to provide trained safety and health professionals to satisfy the increasing needs of Arkansas industries. Until this program was developed however, anyone interested in Industrial Hygiene or Occupational Safety and Health had to leave the state to receive formal training.

Table 1
HEALTH SERVICE DIRECTORS
Arkansas Industries >50 Employees

Director	Number	Percent
Safety Personnel	15	36%
Registered Nurse	10	24%
L P N	10	24%
Other	4	10%
Physician	3	7%
Industrial Hygienist	0	0

services for the workers. Thus, demands are increasing both by industry and the public for health and safety professional strained in the recognition, prevention, and treatment of illness and injury arising out of the workplace.

In a recent report, the U.S. Department of Health and Human Services predicted significant shortages of trained occupational health and safety practitioners by 1992.⁴ Roundtree et al recently looked at environmental health practices in Arkansas and reviewed educational programs pertaining to

Current Occupational Health Practices

In an attempt to characterize the status and scope of employee health services and personnel in Arkansas, a workplace health services survey was developed. The goal of the survey was two-fold: (1) to determine the present status and level of training of personnel involved in employee health services, and (2) to identify areas of future needs for training programs.

Methods

The sample population was selected from the Arkansas Directory of Manufacturers which is published by the Arkansas Industrial Development Foundation. Only companies employing 50 or more people were sampled. All manufacturers listed in the directory in cities beginning with the letters G through Z and having 50 or more employees were mailed a survey. The Standard Industry Codes assigned to each company as well as the number of persons employed by the company as listed in the directory were used as identifiers.

The questionnaire which was developed to be used for data collection included 14 questions. The questions covered:

- * Types of products manufactured
- * Number and length of shifts
- * Presence of an employee health service
- * Title background and training of the health service director
- * Number and titles of employees working in the health service
- * Types of records kept and activity areas
- * Familiarity with Health Risk Appraisals
- * Workshops that would be of interest

Table 2
HEALTH SERVICE DIRECTORS
Training Received

Type Training	Number	Percent
Seminars	23	55%
LPN Training	12	29%
Nursing Degree	10	24%
Business Degree	6	14%
Other	6	14%
EMT Training	4	10%
AOHN	2	5%
Occupational Medicine	1	2%
Medical Assistant	1	2%
Industrial Hygiene	1	2%
None	4	10%

occupational health within the state.⁵ They found that there have been few opportunities for physicians to obtain training in occupational medicine in Arkansas. Of approximately 4500 members of the American College of Occupational Physicians (ACOM), there are nine in Arkansas (including four who are retired).

Fields et al surveyed the content of material relevant to occupational health nursing included in the curricula of all of

Five hundred surveys were mailed to manufacturers who met the above criteria with a short explanation of the goals of the survey. A self-addressed, stamped envelope was enclosed. No personal contact was made with companies in the study population and only one mailing was done.

Table 3

EMPLOYEE HEALTH SERVICES
Types of Records Kept

Record Types	Co. with EHS	Co. without EHS
Lost Work Days	40 (95%)	26 (79%)
OSHA Records and Log	38 (91%)	26 (79%)
Workers Comp Claims	36 (86%)	24 (73%)
Safety Insp. Inform.	34 (81%)	22 (67%)
Med.Insur.Claims/Cost	27 (64%)	22 (67%)
Health Promotion Act.	18 (43%)	4 (12%)

Results

Response to the survey was limited. Only 75 of the 500 manufacturers surveyed (15%) returned completed questionnaires. Of those returned the questionnaire, 56% reported having employee health services (EHS) in their companies. All of the companies with 500 or more employees reporting having an EHS with the smaller companies reporting fewer (Figure 1).

The greatest percent of EHS were directed by safety personnel (35%), while physicians directed 7%, RN's directed 24% and LPN's 24% (Table 1). Ten percent of the employees health service directors reported having no special training or background for their job. By licensure an LPN must work under the direct supervision of a physician or registered nurse. Therefore those LPN program directors are openly practicing in violation of the scope of their licenses. The most often reported source of special training was seminars and special courses, with 55% of the directors

Table 4

WORKSHOPS AND SEMINARS NEEDED

Type of Workshop	Number Interested
Responding to Injuries	39 (52%)
Updates on Occup. Health/Safety	37 (49%)
Drug Testing Issues	34 (45%)
Health Promotion Activities	30 (40%)
Environmental Hazards	29 (39%)
Uses and Benefits of HRA's	28 (37%)

listing these. The specialized training that the remaining directors reported is shown in order of most to least often reported (Table 2).

A majority of companies reported keeping records of lost work days (95% of those with EHS and 79% without). Overall, a higher percentage of companies with an EHS kept records in all the record keeping categories listed than did companies without an EHS, but the difference was not significant (Table 3).

Sixteen percent of the 42 companies that had an EHS reported offering Health Risk Appraisals (HRA) to the employees of their company. Another 21% were familiar with HRAs by did not offer them. Over half of the companies responding (64%) were interested in receiving further information concerning Health Risk Appraisals.

When asked what kinds of workshops or seminars would be most beneficial to their personnel, 52% wanted workshops on responding to injuries. Other topics, with the corresponding level of interest are shown in Table 4.

Activities were listed that might be regularly performed by health service/safety personnel. They were asked to rank the activities according to the amount of time they normally

Table 5

EMPLOYEE HEALTH PERSONNEL
Activities Performed

Type of Activity In Order of Time Spent

- Documentation/Accident Reports Insurance Claims
- Emergency/Injury Care
- New Employee Exams and Interviews
- Safety Inspections
- Meetings with Management
- Employee Counseling
- Physicals
- Routine Sick Call
- Health Education Promotion
- Drug Testing
- Exercise/Physical Fitness Programs

spent on each activity. Accident reports and insurance claims along with emergency/injury care and routine new employee exams were listed as the most common activities. Health education and promotion, drug testing and physical fitness programs were the least commonly performed duties. Table 5 displays the activities listed in order of time spent as reported by all 75 of the responding companies.

Limitations

The sample population represents only companies listed as manufacturers. Service organizations such as hospitals and schools which represent a large proportion of employers in Arkansas were not included. Also excluded were employers with fewer than 50 employees. The selection of this limited population may bias results towards larger, more highly visible and regulated companies who are more likely to have organized employee health services.

No follow up was done to try to increase the return rate. It can be speculated, that a large percent of those failing to return the questionnaire likely have no employee health service to report and thus disregarded the survey. This would result in the percent of manufactures reporting the presence of an employee health service being falsely high.

Conclusions

- * Of the companies responding, 56% reported having an employee health service. The larger the company the more likely they were to have an EHS.
- * Thirty-six percent of the employee health services were directed by safety personnel.
- * Ten percent of the employee health service directors had no specialized training.
- * Few employees in Arkansas have job site access to health care by a physician.

Recommendations

- * A more extensive survey including phone or personal contact, and a broadened scope of types and sizes of employers should be done. This would enable the development of a more complete database concerning the number and quality of employee health services in Arkansas industries.
- * Additional multifaceted training programs must be developed in Arkansas to train physicians and nurses interested in Occupational Medicine in fill the needs of industry.

Acknowledgements

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Number of deaths	18	Less than 20	10
		20 - 29	47
		30 - 39	69
		40 - 49	27
		50 or more	8
CASES BY SEX			
Male	144		
Female	17		
CASES BY RACE		OPPORTUNISTIC DISEASE	
White	117	Pneumocystic Carinii	72
Black	42	Cryptococcosis	4
Other	2	Kaposi's Sarcoma	1
		Candida	26
		HIV Wasting Syndrome	24
CASES BY RISK GROUP		Toxoplasmosis	5
Homosexual/Bisexual	98	HIV Encephalopathy	8
Homosexual & IV Drug User	16	Histoplasmosis	11
IV Drug User	17	Other Diseases	10
Hemophiliac	4		
Transfusion	6		
Heterosexual (Contacts)	8		
NIR#	12		
# No identified risk group (NIR)			

AIDS IN ARKANSAS

1985 - 1990

Total number of cases reported		414	CASES BY AGE GROUP	
Number of deaths		253	Less than 20	13
			20 - 29	129
			30 - 39	185
			40 - 49	59
			50 or more	28
CASES BY SEX				
Male		376		
Female		38		
CASES BY RACE				
White		310		
Black		99		
Other		5		
CASES BY RISK GROUP				
Homosexual/Bisexual		262		
Homosexual & IV Drug User		44		
IV Drug User		44		
Hemophiliac		6		
Transfusion		18		
Heterosexual (Contacts)		21		
NIR#		19		
# No identified risk group (NIR)				
			OPPORTUNISTIC DISEASE	
			Pneumocystic Carinii	193
			Cryptococcosis	19
			Kaposi's Sarcoma	12
			Candida	54
			HIV Wasting Syndrome	41
			Toxoplasmosis	8
			HIV Encephalopathy	24
			Histoplasmosis	27
			Other Diseases	36
Source: Arkansas Department of Health.				

Source: Arkansas Department of Health.

Gerberding, M.D., Julie L. . .

Fourth Annual AIDS Seminar

Julie Gerberding, M.D., of San Francisco, California, will be the afternoon speaker for the Arkansas Medical Society's Fourth Annual AIDS Seminar on Saturday, April 27, 1991. Dr. Gerberding's session has been incorporated as part of the program for the Specialty Section Meetings during the 1991 Annual Session.

This seminar is intended for all physicians and all specialties.

Dr. Gerberding is the Director of HIV Counseling and Testing Service at San Francisco General



"HIV infection is no longer an uncommon disease treated only by a few specialists. Many will treat, care and counsel HIV-infected patients and their families. AMS members need to attend this seminar."

*Joseph Beck, II, M.D.
Committee Chairman
AMS Committee on AIDS*

Hospital and is Assistant Professor of Medicine at the University of California. She has authored or co-authored articles and/or abstracts on HIV in the *New England Journal of Medicine*, 1985, 1986; *Journal of Infectious Disease*, 1987, 1989; *American Society for Microbiology*

Interscience Conference, 1987, 1989; and the AMA HIV Infection and Disease, 1989.

The afternoon program will also include a group panel, which will include Dr. Gerberding and Arkansas physicians.

The panel discussion will provide you an opportunity to ask about nosocomial infections in health care workers and other related matters.

The 1991 AIDS Seminar will begin at 9:00 a.m. as part of the Society's Annual Session program and will focus on the socio-economic aspect of AIDS. The seminar will provide CME Credit for attendees.

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Lack of Communication

Robert J. Miller*

In many areas of the medical environment, the primary physician acts as a quarterback, coordinating patient care, providing information, both to the patient as well as to other members of the health care team. If the physician fails to provide this leadership, the patient is likely to suffer.

In each of the following three cases, lack of follow-up in the coordination of patient care resulted in serious injury and/or death to the patients—who would eventually become the plaintiffs.

Assumption #1

In this case, an assumption that a patient required treatment for only one condition led to a failure to make a second diagnosis—with resultant life-threatening consequences.

The plaintiff was a recently retired plant foreman in his early 60s. Since 1969 he had been the patient of an internist practice comprised of a 56-year old board-certified internist and a 36-year old non-board certified internist. A vascular surgeon was also eventually named as a defendant.

From the internists, the plaintiff had been receiving treatment for diabetes and hypertension. In 1975, he had undergone an arterial graft. In November 1984, the patient began complaining of epigastric discomfort and chest pain. A stress test was administered by the internists and he was then referred for cardiac workup. Ultimately, a bypass operation was performed on December 11.

Unfortunately, the patient's abdominal symptoms continued. Five days later, an upright chest x-ray revealed a large amount of free subdiaphragmatic air as well as peritoneal fluid. But the patient was discharged from the hospital on December 18—only to be readmitted two days later. Eight days lapsed before a diagnosis of ruptured appendix was made as a result of laparotomy, performed on December 26. The abdominal abscess was drained, but two subsequent laparotomies were required for further drainage of abdominal abscesses, one performed on January 21, 1985 and the

other on February 21, 1985. The patient was discharged from the hospital on March 5, following a 2 1/2 month stay. He was readmitted in June and again in August of the following year for his fourth and fifth laparotomies. Patient died the following year, approximately 2 1/2 years following his bypass surgery. His family maintained in the suit that the numerous infections and repeated surgeries weakened his health and led to his eventual death.

Expert witnesses were critical of the physicians' care, claiming that interpretation of a December 16 x-ray should have given indication that further follow-up was necessary in light of the continued epigastric complaints. Lack of aggressive attention to the worsening epigastric problems led to an eventual payment of nearly a quarter of a million dollars.

It is interesting that commentary on this case indicates that care of the cardiac complaints was thorough and complete, but when it came to further investigation of the epigastric problems, one expert called care provided by the same physicians, "lackadaisical."

Assumption #2

The assumption that another physician had given the patient all necessary information or treatment led a 47-year old board-certified general practitioner to the courtroom.

A 58-year old salesman had been treated for a broken arm by his regular physician. X-ray reports revealed a pathological fracture of the humerus and further follow-up was recommended in a written report by the radiologist. But the patient changed physicians and the follow-up never occurred. The second physician became ill and a third physician the general practitioner, saw the patient in mid-December two months after the fracture. He had access to the patient's records and to the radiologist's report. This physician was told by the patient that he was being treated by a specialist for bone cysts. The general practitioner assumed the other specialist would provide follow-up care for the possibly cancerous arm. However, no doctor had spoken with the patient about the possibility of his arm having a cancerous condition.

* Robert J. Miller is vice president-Consumer Affairs and Risk Management for The Medical Protective Company of Fort Wayne, Indiana.

It was not until June of the following year that the patient was informed that he had cancer. The cancer had originated in his kidney and then metastasized to the bone. The kidney was treated surgically in June and in October a bone transplant obviated the need for arm amputation; however, the arm was left non-functional.

The radiologist assumed that his recommendation would be acted upon; the general practitioner who stepped in to handle the case for his ill colleague, assumed that the patient was receiving treatment from the bone cyst specialist. Nobody talked with the patient, nobody asked the patient what care he might be receiving from other doctors or what any of them might have told him; nobody picked up the phone and called one of the other physicians to consult about coordination of the patient's care.

The patient suffered severe disfigurement of his left arm which is now essentially useless. The delay in his treatment resulted in a payment by the general practitioner to remove him from the suit. Numerous other physicians continued as plaintiffs in what would eventually result in a very expensive verdict.

Assumption #3

The assumption that all laboratories are created equal led to this lawsuit involving a 52-year old board-certified pathologist.

The patient, and eventual plaintiff, in this case was a 34-year old teacher, married and the mother of three minor children. The patient had been in the habit of having yearly pap smears performed by her gynecologist. For several years the gynecologist had been using the services of a certain laboratory. However, beginning in 1985, the gynecologist chose to use the services of another lab. The plaintiff eventually claimed that the smears sent to this lab had been misread and poorly interpreted. By the time her cancer was diagnosed, doctors decided that her cancer was inoperable. She underwent both radiation and chemotherapy, but eventually was hospitalized, was placed on dialysis when both her kidneys shut down and subsequently she died. The suit alleged that the three years during which the defendant doctor's laboratory was reading the pap smears could have provided sufficient time to save the patient's life, had the diagnosis been made.

Interestingly, the plaintiff had a twin sister who'd once had a Class V pap smear; cryosurgery was undertaken immediately and there has been no further indication of cancer. Moreover, both sisters used the services of the same gynecologist. The resultant criticism of the pathologist's reports over a three-year period of time and the plaintiff's position in the community as a parent, spouse, educated community leader and educator made defense of the suit doubly difficult. The case was settled for nearly a million dollars.

It would be well to have a close working relationship with outside labs, to know their standards and guidelines and to have a clear understanding of what types of procedures they expect from the office providing smears of blood work

or tissue samples. The assumption that everything was as it should be may have cost the plaintiff her life.

It was a small element in each of these cases that resulted in human misery—and enormous financial loss. The follow-up actions that could have produced positive results were: increased communication between members of the health care team, including those individuals who provided analysis of x-rays or slides. If there is a question in the doctor's mind about the activities of another member of the health care team, it is much the better course of action to pick up the telephone and call that individual to clarify the proposed next step; to provide specific information and recommendations to the patient; to preserve in the records entries regarding phone conversations and copies of memos that include diagnostic or treatment recommendations.

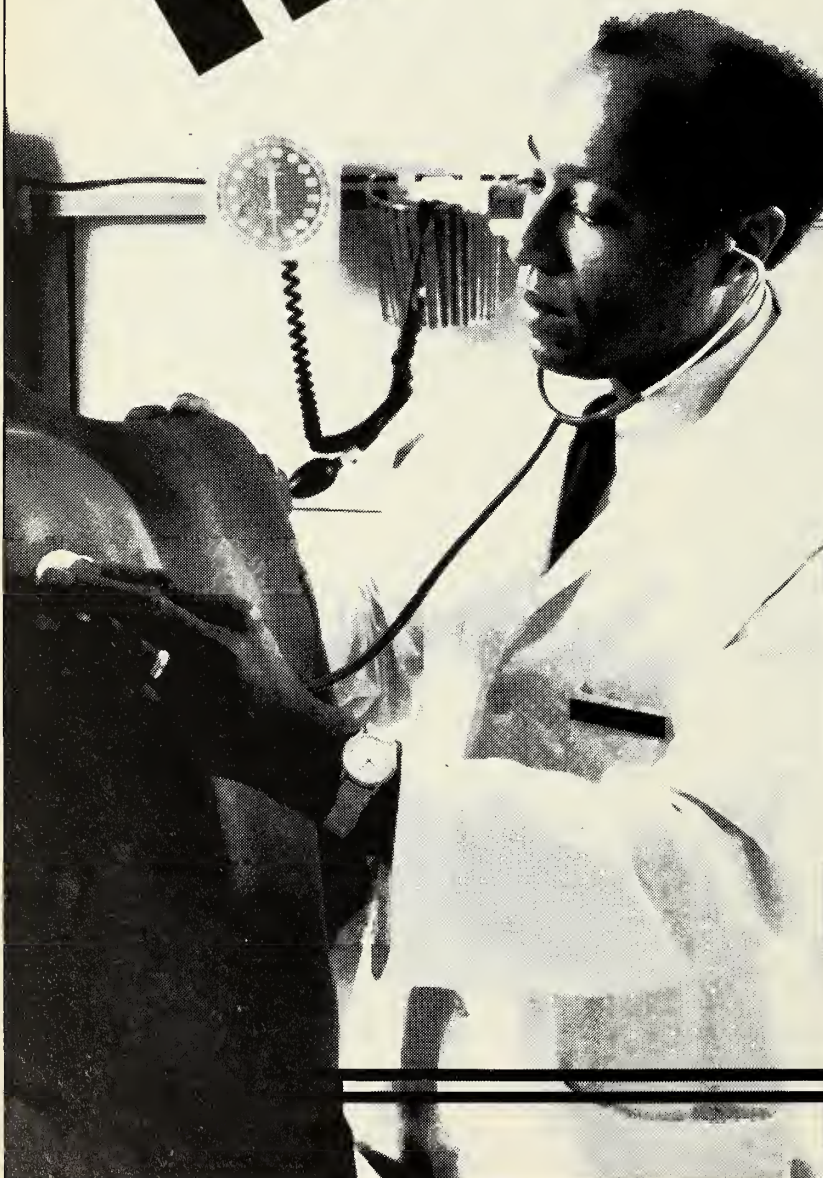
It is certainly true that the extra phone call, the comprehensive entry of information into records, and additional time spent with a patient may add to the physician's work load. Some may be tempted to view this type of communication as a straw that may not break the camel's back, but can surely be exhausting.

But there is another way to think of it: the average length of time involved in bringing each of these suits to a resolution was eighteen months. That's eighteen months of research, interviews, depositions, court appearances. But for those physicians who were named as defendants the time span probably seemed like eighteen years.

The average loss expenditure for these cases was \$388,000. This amount does not include a massive award expected to be paid by the insurer of a defendant who is still included in one of these suits. Attorneys project that the payment for this one defendant will be well in excess of \$250,000. If this is true, the average payment for these suits comes closer to \$470,000, excluding emotional wear and tear. In the long run, effective communication prevents many lawsuits.

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Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

Continuing Medical Education Luncheon, second Friday, 12:30 p.m. AMI Ozark-Quapaw Room. One Category I credit per meeting.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), third Wednesday, 12:30 p.m., Conference Room, Building 1, VAMC

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Faculty Resident Seminar, third Thursday, 12:00 noon, Sturgis Auditorium

Genetics Conference, Wednesdays, 12:00 noon, Sturgis Building, Room 457

Infectious Disease Conference, second Wednesday, 12:00 noon, 2nd Floor Classroom

Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Building, Auditorium

Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., 2nd Floor Classroom

Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, 2nd Classroom

Pediatric Research Conference, first Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

Sleep Disorders Case Conference, third and fifth Thursday in November and second and fourth Thursday in December. Lunch provided.

Interdisciplinary AIDS Conference, second Friday, 12:00 noon. LaHarpe Room. Sandwich buffet is served.

Cancer Conference, third Thursday, 12:00 noon, Laboratory Conference Room. Lunch is provided.

Hematology-Oncology Conference, second Thursday, 12:00 noon. Lunch is provided.

Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Southwestern Bell/Arkla Room. Refreshments are provided.

Pulmonary Conference, second and fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla Room. Sandwich buffet is served.

Journal Club, every Tuesday, 12:00 noon, Conference Room 1. Lunch is provided.

GYN Surgery Cancer Conference, second Monday, 12:00 noon. Lunch is provided.

Joint Tumor Conference, first Wednesday, 12:00 noon. CARTI Auditorium. Lunch is provided.

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., Conference Room 1

Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lectures and case presentations. A light lunch is provided.

Pathology Conference, third Tuesday, 3:00 p.m., Pathology Library

Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. A light lunch is provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC Oncology Forum, fourth Thursday, 4:00 p.m., UAMS ACRC 2nd Floor Conference Room, 1.5 credits

Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B

Anesthesia Morbidity and Mortality Conference, second and fourth Tuesdays, 6:45 a.m.; first, third and fifth Thursdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B

CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy

Cardiothoracic Surgery Conference, first Thursday, 8:00 a.m., location varies

Child Psychiatry Clinical Case Conference/Research Review, most Fridays, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room

Dermatopathology Conference, Tuesdays, 8:00 a.m., UAMS Education Building, Room G/108 A&B

Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Building, Room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Building, Room G/110A&B
Emergency Medicine Grand Rounds 1, third Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Grand Rounds 2, third Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology Conference Room, #M1/293.
Hematology Fellow's Forum, second, third, and fourth Fridays, 8:15 a.m., ACRC Betsy Blass Conference Room
Hematology/Oncology Clinical Problems Conference, Thursdays, 8:15 a.m., LRVA Pathology Conference Room
Interdisciplinary Gynecologic Cancer Conference, Fridays, 12:30 p.m., UAMS Education Building, Room G106 A&B
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., St. Vincent Infirmary Education Bldg., Arkla/Bell Room
Little Rock Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC Conference Room three times per month, CARTI Auditorium one time per month
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Building, Rom G/131A&B
Medicine Research Conference, three Wednesdays per month, 4:30 p.m. Shorey Building, Room 3S06
Neurology Clinical Case Conference, Thursdays, 8:00 a.m. VAMC-LR Room 2D109
Neuropathology Conference, Thursdays, 10:00 p.m. UAMS Morgue
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Ob/Gyn Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Building, Room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, Room 3/150, 2 credit hours
Orthopaedic Basic Science Conference, occasional Tuesdays, 11:00 a.m., UAMS Education Bldg., Room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Building, Room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Building, Room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Building, Room B/135
Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Shorey Auditorium
Surgery Basic Sciences Conference, first Saturday, 7:30 a.m., ACRC 2nd floor conference room
Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room
Surgery Morbidity and Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room
Surgery Resident Case Conference, second, third, fourth, fifth Saturday, 7:30 a.m., ACRC 2nd floor conference room
Surgery Staff/Clinical Case Conference, alternating Tuesdays, 7:00 a.m., UAMS Education Building, Room G/141
Surgery Vascular/Radiology Conference, Tuesdays, 5:00 p.m., VAMC-LR Radiology Conference Room
Surgery Vascular Teaching Conference, Thursdays, 3:00 p.m., VAMC-LR Radiology Conference Room.
Urology Basic Sciences Conference, second Wednesday, 5:00 p.m., UAMS Education Building, Room G/106A&B
Urology Clinical Didactic Conference, third Tuesday, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
Urology Core Conference, once or twice monthly, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
Urology Grand Rounds, second and fourth Tuesday, 5:00 p.m., VAMC-LR (4D)
Urology Morbidity and Mortality Conference, last Wednesday, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
Urology Teaching Conference, once or twice monthly, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
Uro-Radiology Conference (Urologic Imaging), once monthly, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
VA Chest Conference (combined Surgical/Medical Chest Conference), alternating Mondays, 12:15 p.m., VAMC-LR, Room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine Conference Room, Room 1D173
VA Geriatric/Gerontology Research Conference, Wednesdays, 3:15 p.m., VAMC-LR, Room 1E123
VA Hematopathology Conference, Wednesdays, 3:00 p.m., VAMC-LR Pathology Conference Room
VA Lung Cancer Conference (combined Medical/Surgical Lung Cancer Conference), Tuesdays, 3:00 p.m., VAMC-LR, Room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Building 68
VA Medicine-Pathology Conference, Tuesday, 2:00 p.m., VAMC-LR, Room 2D109
VA Medicine Service Resident's Clinical Case Conference, Fridays, 12:00 noon, VAMC-LR, Room 2A109
VA Physical Medicine and Rehab Grand Rounds, fourth Friday, 11:00 a.m., VAMC-NLR Building 68, Room 118 or Arkansas Rehab Institute
VA Psychological Assessment Conference, Tuesdays, 3:00 p.m., VAMC-LR & NLR Psychology Department, 1.5 credit hours
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, Room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine Conference, Thursdays, 8:00 a.m., VAMC-NLR Building 68, Room 118
VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology Conference Room

EL DORADO - AHEC

Behavioral Sciences Conference, first and fourth Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, second Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second and fourth Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, fourth Thursday, 12:30 p.m., AHEC-South Arkansas

Surgical Conference, first, second and third Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

Behavioral Sciences Conference, third Wednesday, 12:00 noon, Washington Regional Medical Center
City Hospital Staff Medical Meeting, second Friday, 12:00 noon, Fayetteville City Hospital
Family Medicine Conference, first, third, fourth Thursday; fourth Wednesday; second Thursday (odd months) AHEC-NW, 241 W. Spring, Fayetteville
Interesting Case Conference, 1st and 3rd Friday, 12:00 noon, Fayetteville City Hospital
Medicine Conference, first and third Tuesday, 12:00 noon, Washington Regional Medical Center
OB/GYN Conference, December 13, 12:00 noon, AHEC Conference Room
Pediatric Conference, second Wednesday, 12:00 noon, Washington Regional Medical Center
Radiology Conference, December 5, 12:00 noon, Washington Regional Medical Center
Nutrition Conference, November 7, 12:00 noon, Washington Regional Medical Center
Surgery Conference, second Tuesday, 12:00 noon, Washington Regional Medical Center Fulbright Board Room

FORT SMITH - AHEC

Internal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center
Pediatric Cardiology, November 21, 12:00 noon, Sparks Regional Medical Center, 7th floor dining room
Issues in Ventilator Weaning, November 28, 12:00 noon, Sparks Regional Medical Center, 7th floor dining room

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first and third Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.
Chest Conference, second Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided
Craighead/Poinsett Medical Society, first Tuesday, 7:00 p.m. Jonesboro Country Club
Eaker AFB CME Conference, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria
Independence County Medical Society, second Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, fourth and fifth Tuesday, 12:00 noon, St. Bernards Dietary Conference Room. Lunch provided.
Jackson County Medical Society, third Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, third Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, second Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neuroradiology Conference, third Friday, 12:00 noon, St. Bernards Dietary Conference Room. Lunch provided.
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Pocahontas CME Conference, third Wednesday, 12:00 noon and 7:30 p.m., Randolph County Medical Center Boardroom
Tumor Conference, 2nd Thursday, 4th Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided
Walnut Ridge CME Conference, third and last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

PINE BLUFF-AHEC

Behavioral Science Conference, first and third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second and fourth Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, first and fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, second and fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second and fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Neuro-Radiology Conference, first and third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

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New Members

CRAIGHEAD/POINSETT COUNTY

Cranfill, General Lee, Internal Medicine, Jonesboro. Born January 31, 1962, Friona, TX. Medical education, University of Texas at Houston, 1987. Internship/residency, UAMS, 1990. Pending certification.

JACKSON COUNTY

Conrady, Rickie A., Family Practice, Newport. Born November 18, 1954, Enid, OK. Medical education, University of Oklahoma College of Medicine, Oklahoma City, 1981. Internship/residency, Wesley Medical Center, Wichita, KS, 1984. Practice experience, six years. Board certified.

PULASKI COUNTY

Boehm, Timothy M., Endocrinology, Metabolism & Diabetes, Little Rock. Born October 9, 1946, Little Rock. Medical education, Duke University School of Medicine,

Durham, NC, 1971. Internship/residency, University of North Carolina Memorial Hospital, Chapel Hill, NC, 1972; Walter Reed Army Medical Center, Washington, D.C., 1976. Practice experience, 14 years. Board certified.

Bogost, Bruce R., Psychiatry, Little Rock. Born January 5, 1932, Milwaukee, WI. Medical education, Marquette University, Milwaukee, WI, 1959. Internship, Mt. Sinai Hospital, Milwaukee, 1960. Residency, Milwaukee General Hospital, 1962; Medical College of Wisconsin, Milwaukee, 1971. Practice experience, 19 years.

SEBASTIAN COUNTY

Phillips, Kevin C., OB/GYN, Fort Smith. Born August 28, 1958, Little Rock. Medical education, UAMS, 1985. Residency, University of Kansas, Kansas City, 1989.

AMS Newsmakers

Baptist Medical Center has teamed with more than 30 Central Arkansas pediatricians to organize an after hours clinic for sick and injured children.

The clinic, which opened in October, is open nights and weekends when most physicians' offices are closed.

The clinic was designed as an alternative for parents who otherwise would use the emergency room, where they often were forced to wait while more serious trauma cases were seen first.

Jack Brackin, M.D., of Huntsville, has been named to the board of directors of the Huntsville Memorial Hospital.

William C. Glover, M.D., of Little Rock, has been named a Fellow of the American College of Radiology.

Sanford E. Hutson, M.D., of Texarkana, TX, has been named a Fellow of the American Academy of Family Physicians.

Jerry L. Prather, M.D., of Little Rock, has been named a Fellow of the American College of Radiology.

John F. Redman, M.D., a Little Rock urologist, was

elected president-elect of the Southern Medical Association during the group's annual Scientific Assembly. Dr. Redman is professor and chairman of the Urology Department and professor in the Pediatrics Department at the University of Arkansas College of Medicine.

James R. Weber, M.D., of Jacksonville, was elected to the board of directors of the American Academy of Family Physicians by the AAFP Congress of Delegates at their recent meeting. Dr. Weber will serve a three-year term.

Dr. Weber's election marks the second time in seven years that an Arkansas Academy of Family Physicians member has been elected to the AAFP board of directors.

Dr. Weber was also elected to chair the AAFP Commission on Health Care Services for the coming year.

Dr. Weber is in private practice and is an assistant clinical professor in the department of family and community medicine at the University of Arkansas Medical Sciences campus.

Robert Wilson M.D., of Huntsville, has been elected to the board of directors of the Huntsville Memorial Hospital. Dr. Wilson is in family practice at the Huntsville Clinic.

Minutes of the House of Delegates of the Arkansas Medical Society

Speaker of the House John Crenshaw called the House of Delegates to order at 12:00 noon, Sunday, October 28, 1990. The invocation was given by Payton Kolb. Members of the House seated were:

Officers

President	William N. Jones
First Vice President	Michael Moody
President-elect	George Warren
Speaker of the House	John Crenshaw
Vice Speaker of the House	Kelsy J. Caplinger
Treasurer	James M. Kolb Jr.
Past Presidents	John P. Burge W. Payton Kolb Ben N. Saltzman John M. Hestir T. E. Townsend

Councilors

District 1	J. Larry Lawson
District 2	Merrill J. Osborne
District 3	not represented
District 4	L. J. P. Bell
District 5	Hoy Speer
District 6	Lloyd Langston
District 7	Paul A. Wallick
District 8	Cal R. Sanders
District 9	Wayne Elliott
District 10	James D. Armstrong
	Ronald J. Bracken
	Glen F. Baker
	Warren Douglas
	Charles Logan
	Robert H. Langston
	David Rogers
	A. C. Bradford

Delegates:

Cleburne County	J. Warren Murry
Dallas County	Don Howard
Independence County	Lloyd G. Bess
Jefferson County	Lee A. Forestiere
	Anna T. Ridling
	Ruston Pierce
Medical Student Section	John Gaston
Miller County	John A. Gillean
Pulaski County	Raymond V. Biondo
	Fred O. Henker
	John F. Redman
	Jim English
Washington County	Janet Titus

The following business was transacted:

1. Speaker Crenshaw introduced John Redman, president-elect of the Southern Medical Association.
2. Mr. Lynn Zeno introduced our featured speaker, John Lipton, speaker of the House of Representatives. Rep. Lipton discussed a survey that was conducted among the House members to obtain a clearer understanding of their perception of what the issues are throughout the state. Rep. Lipton made a presentation outlining the results of the survey.
3. John Burge, chairman of the Ad hoc Committee on the AMA's Proposed Health Access America Plan, discussed the committee's recommendation and made a motion that the House of Delegates vote to approve the action of the council which endorsed the concept of Health Access America as proposed by the AMA. The motion passed unanimously. Refer to the AMA's Health Access America Plan following the minutes.
4. Upon a motion by Janet Titus, the House of Delegates approved the Washington County Medical Society's resolution regarding transporting children and adolescents in the back of a pickup truck. The motion passed unanimously. Refer to the resolution following the minutes.
5. Lynn Zeno, director of Governmental Affairs, discussed 1991 legislation as proposed by the Governmental Affairs Council.
6. Upon a two-thirds vote from the floor, Michael Moody made a motion that the Arkansas Medical Society go on record supporting in concept the request from the Department of Human Services that those physicians participating in the Medicaid program be taxed quarterly 2% of the amount received in Medicaid dollars. The money collected would be used as matching monies netting the physicians approximately a 20% increase in reimbursement. The motion also stated that this issue be referred to the Department of Governmental Affairs for further study and that they be given the authority to act on behalf of the House at the completion of the study. The motion passed unanimously.

After lengthy discussion on legislative issues, the House adjourned until April 25, 1991.

The elements of the AMA proposed plan are summarized in the following 16 points:

1. Effect major Medicaid reform to provide uniform adequate benefits to all persons below the poverty level. The AMA Medicaid Reform proposal would set new national requirements to assure that in all states persons below poverty income levels are eligible for and receive a uniform set of adequate benefits, so that no poor person is left without access to needed health care.
2. Require employer provision of health insurance for all full-time employees and their families, with tax help to employers. About 24 million of the 33 million uninsured are employed individuals and their families. Tax incentives must be provided and risk pools created so that new and small businesses can afford the cost of such coverage.
3. Create state-level risk pools in all states to make coverage available for the medically uninsurable, for whom access to coverage is not available, and for others for whom individual health insurance policies are too expensive and group coverage is not available.
4. Enact Medicare reform to avoid the future financial bankruptcy of the program by creating an actuarially sound prefunded program to assure senior citizens continued access to quality health care.
5. Expand long-term care financing through expansion of private sector coverage encouraged by tax incentives and an asset protection program, and provide Medicaid coverage for those below poverty.
6. Reduce health care costs through professional liability reform to reduce the inappropriate cost of such insurance and defensive medicine. Would include federal funding to states to demonstrate alternative dispute resolution systems for medical professional liability cases, and federal tort reforms.
7. Develop professional practice parameters to help assure that only high quality appropriate medical services are provided, thus impacting favorably on the quality and cost of medical care. The primary benefit of parameters is appropriate patient care. Secondary advantages include improved use of resources, reduced liability, and better review criteria.
8. Alter the tax treatment of employee health care benefits to reward people for making economical health care insurance choices. The two tax reforms would place a limit on the amount of the employer-provided health insurance that is tax-exempt to the employee and would provide tax-exempt rebates to employees who select health insurance plans with premiums less than their employer's contribution to more expensive plans.
9. Encourage cost-conscious decisions by patients, for example, through insurance companies, employers and government programs providing patients more information, prior to service, of the amount insurance or the program will cover.
10. Seek innovation in insurance underwriting, including new approaches to creating larger risk spreading groups and reinsurance.
11. Urge expanded federal support for medical education, research and the National Institutes of Health (NIH), to help bring about continuing medical breakthroughs which historically have resulted in many lifesaving discoveries.
12. Encourage health promotion and disease prevention. For example, one recent estimate indicates that 35% of all hospitalized patients are there due to an alcohol or drug abuse problem. Recent estimates by the Centers for Disease Control's Office of Smoking and Health indicate that 390,000 Americans die each year from tobacco-related illness and that the direct health care dollar costs related to such illness is about \$22 billion per year.
13. Amend ERISA or the federal tax code so that the same standards and requirements apply to self-insured (ERISA) plans that apply to state-regulated health insurance policies. Currently, this "unequal playing field" removes the self-insured plans from equitable participation in state risk pools, leaving many people without access to affordable health insurance, including small employers.
14. Repeal or override state-mandated benefit laws, to help reduce the cost of health insurance, while assuring through legislation that adequate benefits are provided in all insurance, including self-insurance programs.
15. Seek reductions in the administrative costs of health care delivery and the excessive and complicated paperwork nightmare faced by patients and their families who seek to obtain benefits.
16. Maintain quality and access through encouraging physicians to practice in accordance with the highest ethical standards and to provide voluntary care.

Resolution

Resolution from the Washington County Medical Society Regarding Transporting Children & Adolescents in the Back of Pickup Trucks

Whereas, Arkansas physicians are genuinely concerned about the health and safety of our citizens, and

Whereas, the health and safety of children and adolescents is needlessly placed at risk when riding as unrestrained passengers in automobiles and in the back of pickup trucks, and

Whereas, legislation has already been passed requiring the use of automotive restraints for children of certain ages, and

Whereas, the Arkansas Medical Society continually supports the passage of mandatory seat belt laws for the purpose of saving lives; and

Whereas, further efforts are needed to prevent injuries from occurring in the back of pickup trucks, therefore be it

RESOLVED, that the Washington County Medical Society urges the Arkansas Medical Society to support the passage of legislation to halt the transport of children and adolescents in the back of pickup trucks.

Approved by the Arkansas Medical Society House of Delegates 10/28/90

Physician's Opportunity Fair

University of Arkansas for Medical Sciences
Jeff Banks Student Union
October 25, 1990

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First Commercial Bank, N.A. - \$100.00

Mark A. Ringold, M.D.
R2 Medicine

Dean's Office - \$50.00

Susan Haefner
Medical Student

Physician's Recognition Award

The Physician's Recognition Award is awarded each month to physicians who have completed acceptable programs of continuing education. The recipients for the month of October are:

Vilasini D. Jayaraman	Hot Springs
Terryl J. Ortego	Springdale
Robert C. Power	Little Rock
William V. Relyea	Hardy
Kenneth V. Robbins	Little Rock

Medicine in the News

State Ranks Near Top in Traffic Deaths

Arkansas' fatality rate was one of the highest in the nation last year according to the state Highway and Transportation Department.

Statistics recently released show that for 1989 Arkansas was among the top five states in number of traffic deaths computed by miles driven, population and registered vehicles.

Frank Vozel, coordinator of Arkansas' Highway Safety Program, said several factors had placed Arkansas among the worst states for traffic fatalities, but two stand out:

1. It is one of just 14 states that has failed to pass a mandatory safety belt law since 1984.
2. It continues to have an above average number of fatal traffic accidents that involve alcohol.

While the nation has shown a significant improvement in traffic death rates in the last 10 years, Arkansas has not.

Last year, for example, 643 traffic deaths were recorded in Arkansas, up from 610 in 1988.

National Highway Traffic Safety Administration figures show that in states with safety belt laws, 52% of drivers wear belts. But in Arkansas, which does not require safety belts, that rate is 33.6%.

In 1979, Arkansas had a traffic fatality rate of about 3.3 per 100 million miles driven, the same as the national average.

Since safety belt legislation has become prevalent in most states, the national fatality rate has declined significantly, dropping to 2.25 in 1989. Arkansas' rate, however, has consistently stayed between 3.2 and 3.6.

Vozel said in a recent interview that a belt law would have a significant impact on Arkansas fatalities. "There are plenty of statistics that show a reduction of serious injuries in accidents of about 45% for people wearing seat belts."

Previous attempts to make safety belts mandatory in Arkansas have failed, and Vozel said a proposal would come up again in the upcoming session.

Custom Furniture for Homes



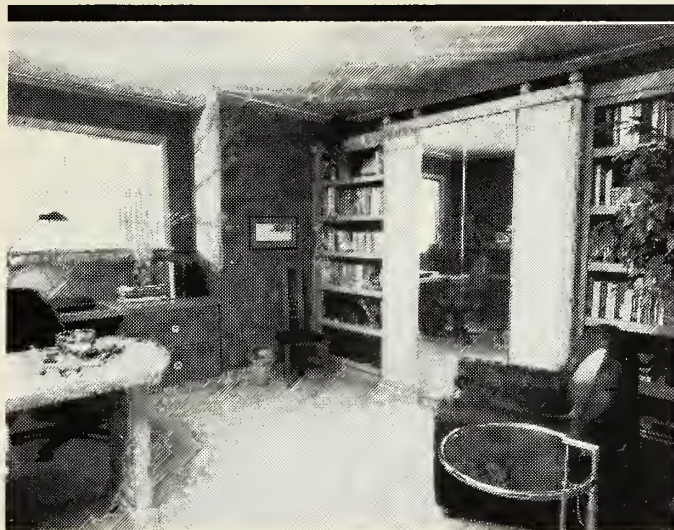
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Change in the Immunization Schedule

The Committee on Infectious Diseases of the American Academy of Pediatrics recently endorsed a change in the schedule for immunizing infants against *Haemophilus influenzae* type B — the major cause of meningitis in children.

"Commonly called the HIV vaccine, it had previously been recommended for children at 15 months," said Russell W. Steel, M.D., professor of pediatrics at Arkansas Children's Hospital and a member of the national committee issuing the endorsement. "...we have endorsed administration of the *Haemophilus influenzae* type B vaccine manufactured by Praxis/Lederle as HibTITER™ for administration on routine basis at two, four and six months of age. In addition, all infants should receive a booster at 15 months."

Dr. Steele said immunization of young infants is important because the peak incidence of meningitis occurs before the end of the first year. *Haemophilus influenzae* type B is the major bacterial cause of meningitis in all children under five years of age.

Health Care Access Foundation Update

As of October 1990, the Arkansas Health Care Access Foundation has provided free medical services to 2,080 medically indigent persons.

The program has 1,445 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.

CPT Codes

The 9th edition of the Physicians' Current Procedural Terminology manual contains some new, underused, or commonly overlooked CPT codes. They are the following:

- * 98900 - Medical conference by physician regarding medical management with patient, and/or relative or guardian; approximately 30 minutes (98902 for 60 minutes).
- * 98920 - Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (billed by length and complexity).
- * 90225 - History and examination of the normal newborn infant (whether or not the physician attended the delivery).
- * 90292 - Hospital discharge day management.

- * 99000 - Handling and/or conveyance of specimen for transfer from office to a laboratory.
- * 36415 - Routine collection of venous blood.
- * 99050 - Services requested after office hours in addition to basic service.
- * 99052 - Services requested between 10:00 p.m. and 8:00 a.m. in addition to basic service.
- * 99054 - Services requested on Sundays and holidays in addition to basic service.
- * 99064 - Emergency care facility services: when the non-hospital-based physician is called to the emergency facility from outside the hospital to provide emergency services, not during regular office hours (use 90065 during regular office hours).
- * 99070 - Supplies and materials (except spectacles) provided by physician over and above those usually included with office visit or other services rendered (list drugs, trays, supplies, or materials provided).
- * 99071 - Educational supplies, such as books, tapes, pamphlets, provided by physician for patient's education at cost to physician.
- * 99080 - Special reports such as insurance forms, or review of medical data to clarify a patient's status - more than the information conveyed in the usual medical communications or standard reporting form.
- * 90755 - Infant care to one year of age, with a maximum of 12 office visits during regular office hours, including tuberculin skin testing and immunization of diphtheria-tetanus-pertussis and oral polio.
- * 90774 - Administration and medical interpretation of developmental cases.
- * 90782 - Therapeutic or diagnostic injection (specify material injected); subcutaneous or intramuscular.

Safe Disposal of Radioactive Wastes

The safe disposal of low-level radioactive wastes affects physicians in many ways that you may not expect. Some 25% to 30% of all low-level wastes produced in the U.S. each year stems from medical uses, like nuclear medicine procedures and the evaluation of new drugs. Waste disposal is an environmental issue. But, due to federal laws passed in the 1980s, it is also a political issue.

Political, not public health problems

Then why is disposal of radioactive wastes a problem?

Actually, disposal has long been more a political than a public health problem. In the 1960s, six licensed commercial facilities received wastes from across the country. After three of these facilities closed, opposition developed in the three remaining host states on the grounds that they should not be burdened with the disposal needs of the entire nation.

In response, Congress passed the Low Level Radioactive Wastes Policy Act in 1980. Under this bill, each state would eventually become responsible for disposal of radioactive wastes generated within its boundaries. The act recommended that states participate in regional groupings or compacts to improve the cost-effectiveness of disposal facilities. It also stated that any regional facility could exclude wastes from outside its region after January 1, 1986.

For the next five years, states moved to negotiate compacts and sign the necessary agreements. The difficulty in locating and gaining approval for disposal sites slowed progress. Remote sites might satisfy public sentiment, but their remoteness disposal convenience and cost.

By 1985, it was clear that states would not meet the 1986 deadline. Congress responded with amendments to the Wastes Policy Act, extending the deadline to January 1, 1993. On that date, the three existing commercial sites — located in Beatty, NV, Richland, WA, and Barnwell, SC — will be closed to outsiders.

State negotiations have proceeded since 1985. Yet selecting a disposal site and preparing to operate a facility involves a complicated series of steps. In its 1988 informational report, the American Medical Association Council on Scientific Affairs said those steps include legislation, government oversight, public participation, financing, engineering, supervision, surveillance, and quality control. Few states are far along in this process and fewer still are expected to meet the 1993 deadline.

Physicians Can Help

Physicians can play a key role in helping their states develop acceptable disposal facilities for low-level radioactive wastes. Their medical training can provide an informed perspective on the personal and public health risks related to waste disposal. But more importantly, they can describe the beneficial uses of procedures that produce radioactive wastes and how these uses will be compromised if disposal sites for the wastes are unavailable.

Consider becoming involved in efforts to establish disposal facilities. First, contact representatives of your state's radiation control program or health agency. Arrange to meet with them, determine whether your state is involved in a compact, and offer your support. Encourage these representatives to consider what will be done if a disposal site is not available by January 1, 1993. Stress the need to develop one or more storage sites for low-level wastes as an intermediate measure until a disposal site becomes available.

Secondly, encourage your medical society's public health or environmental health committee to become involved. Pass policy regarding the disposal of low-level radioactive wastes and then promote it. Through lobbying efforts or by working with public health authorities, the medical society can influence disposal facility plans.

Finally, physicians can help persuade their patients, the media and community groups that radioactive materials can be beneficial. Seek opportunities to lead discussion in classrooms or speak to public audiences.

For further information, contact J. Loeb, Ph.D., Director of the Division of Biomedical Science, American Medical Society, 515 North State Street, Chicago, IL 60610 or call (312) 464-5456.

The History of Medicine in Arkansas

The History of Medicine Associates of the UAMS Library, with assistance from the Arkansas Endowment for the Humanities, has recently published *Contributions to Arkansas Medical History*. The papers included are the winners of the first five History of Medicine Associates Research Awards. Each of the papers provide information about a different aspect of Arkansas health care.

Copies of the book are available, prepaid only, from:

History of Medicine Associates
c/o Special Collections
UAMS Library, Slot 586
4301 West Markham
Little Rock, AR 72205-7186

The cost of the book is \$15.00 plus a \$2.00 postage and handling fee. There is a special price for associate members.

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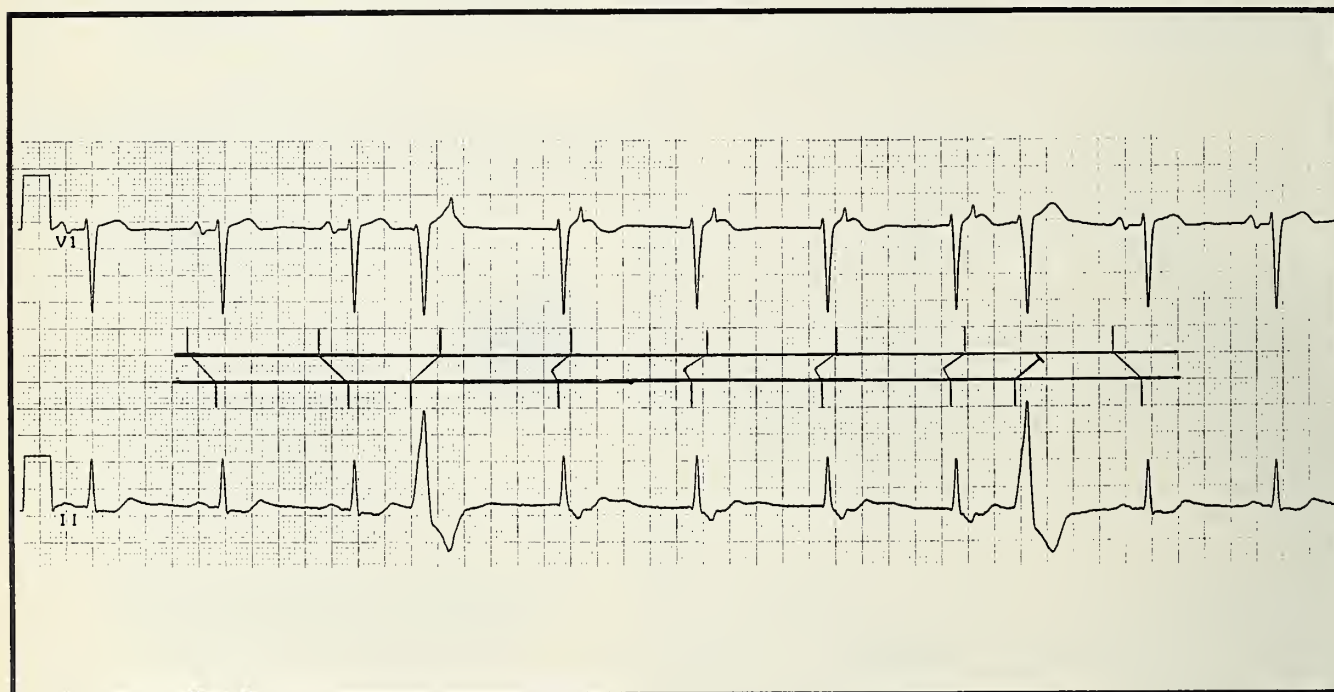


Electrocardiogram of the Month

Jon P. Lindemann, M.D.
UAMS Division of Cardiology
Little Rock, Arkansas

CLINICAL HISTORY:

This record was obtained from a 54 year-old male with a history of end stage renal disease being treated with chronic ambulatory peritoneal dialysis. His medications included: digoxin, 0.125 mg three times weekly; sustained release verapamil, 240 mg daily; metoclopramide, 5 mg daily; ranitidine, 150 mg daily, amitriptyline, 50 mg prn; as well as vitamins and antacids. What is the rhythm?



DISCUSSION:

Two rhythms are present. The first three and the last two complexes represent sinus rhythm. There is a four beat run of an accelerated junctional rhythm, preceded and followed by ventricular premature complexes (VPC's).

The sinus rhythm is at a rate of 61 with a PR interval of 210 msec, which is slightly prolonged. The first VPC is conducted retrogradely to the atrium, resetting the SA node. This delay allows a junctional focus to escape at a rate identical to the sinus rate, simply because the junctional focus was depolarized by the retrograde impulse before the SA node was depolarized. Sinus rhythm resumes after a VPC, which resets the junctional focus, but fails to be conducted retrogradely to the atrium. Generally, slowing of AV conduction ($PR > 200$ msec) and acceleration of subsidiary pacemakers (a junctional focus at a rate $> \text{or} =$ to 60) is a hallmark of digitalis excess. The combination of digoxin and verapamil may result in slowing of AV conduction in the absence of digitalis intoxication.



Dr. Holwick outside of hospital where she practices as a civilian traumatologist.



Dr. Holwick in operating room at Letterman Army Medical Center.

JANN L. HOLWICK, M.D.

General and Trauma Surgeon.
Captain, U.S. Army Reserve.

EDUCATION University of Southern California, B.S.;
University of California School of Medicine.

RESIDENCY Harbor General Hospital—UCLA
Medical Center.

HOSPITAL AFFILIATIONS St. Luke Hospital;
Huntington Memorial Hospital, Pasadena, California;
Traumatologist, Arcadia Methodist Hospital, Arcadia,
California.

OUTSTANDING ACHIEVEMENTS Borden
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Am Fam Phys 1987;36:133-140

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Consult the package literature for prescribing information. Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Cecilor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of non-susceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Cecilor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Cecilor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions have been reported with the use of Cecilor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, serum-sickness-like reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Cecilor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
- Stevens-Johnson syndrome, toxic epidermal necrolysis,

and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.

- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

Abnormalities in laboratory results of uncertain etiology:

- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
- Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Cecilor and Coumadin concomitantly.
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinistix® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).

PA 8791 AMP [021490LR] Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.



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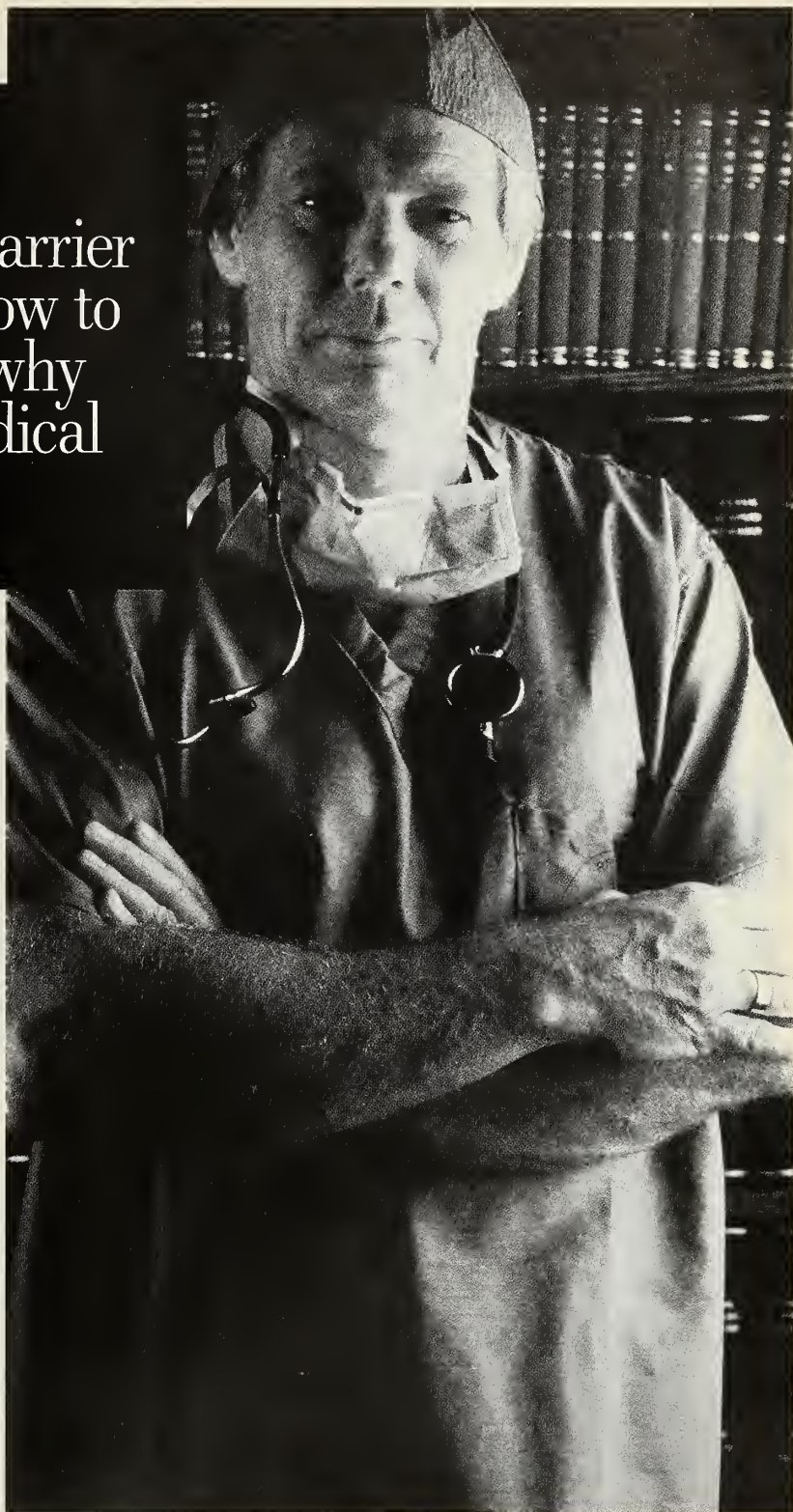
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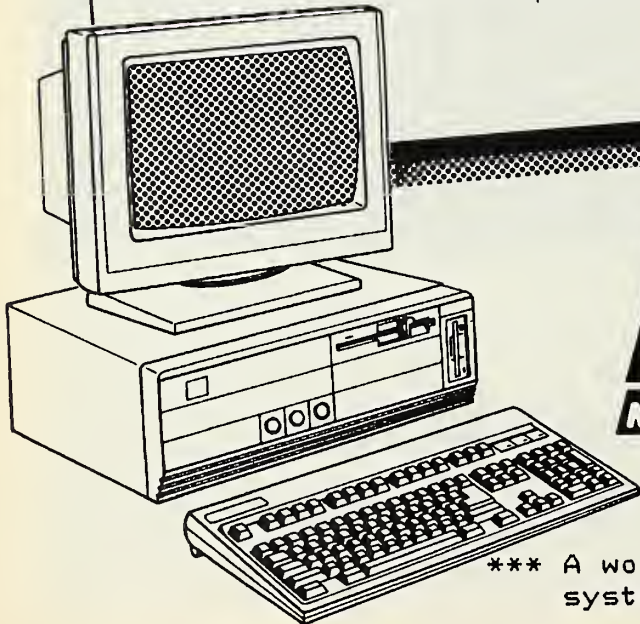
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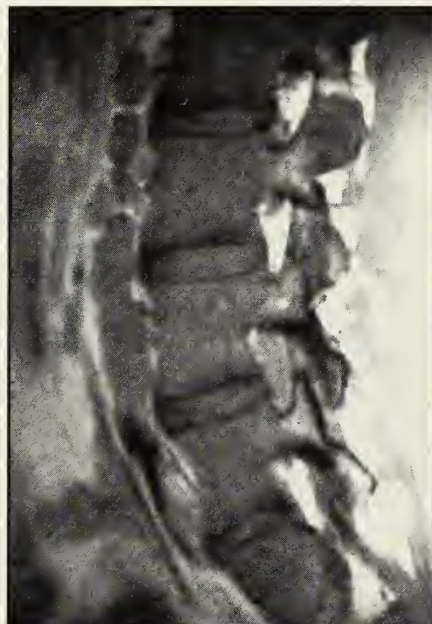
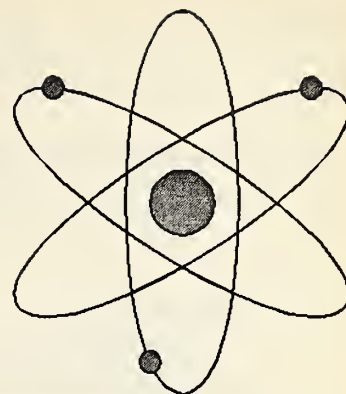
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Radiological Case of the Month

Steven R. Nokes, M.D.
G. Morrison Henry, M.D.
Anthony Bucolo, M.D.
David L. Harshfield, M.D.



Figures 1a and 1b. Sagittal T1-weighted images of the lumbar spine

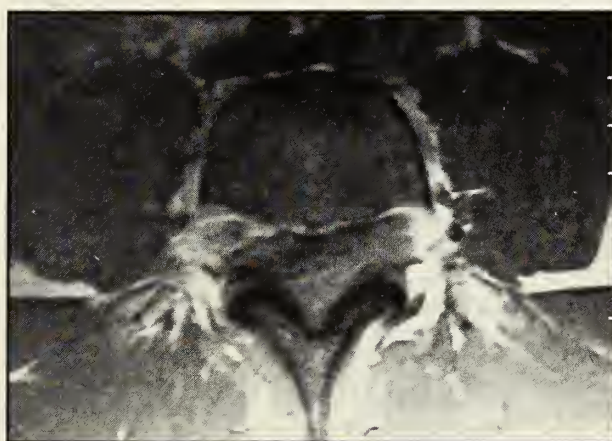


Figure 2. Axial T₁-weighted image at L_{4/5}

History:

A 19 year-old male presented with low back pain and left leg pain in a radicular distribution. An MR scan was performed. Shown are sagittal (Figures 1a and 1b) and axial (Figure 2) T₁-weighted images of the lumbar spine.

Hodgkin's Lymphoma

Findings:

The MR scan reveals a homogeneous posterior extradural mass extending from L₃₋₄ to L₅-S₁ with extension into the left L₄₋₅ intervertebral foramen, markedly compressing the thecal sac. In addition, there are multiple periaortic lymph nodes, seen predominantly on the left on the axial image and on the sagittal image 1b.

Discussion:

The differential diagnosis of an extradural mass with adenopathy should include lymphoma and metastatic disease. A bulky soft tissue mass insinuating itself into foramina, extending over multiple segments and producing less skeletal involvement than expected for lesion site should suggest and correct diagnosis.

Approximately 6% of patients with lymphoma exhibit extradural spinal involvement. The thoracic spine is most commonly affected (69%), with 27% of cases involving the lumbar spine. The cervical spine is uncommonly involved (4%). Plain film spinal osseous abnormalities, such as compression fractures and erosion of pedicles occur in 30% of cases. Extradural involvement is approximately three times more common in non-Hodgkin's lymphoma than Hodgkin's disease. The majority of patients with Hodgkin's disease have a proven histologic diagnosis prior to the onset of spinal cord compression syndrome, whereas only 15% of those with non-Hodgkin's lymphoma have previously been diagnosed.

Management of extradural compression of the spinal cord or cauda equina in patients with lymphoma is controversial. There has been no large trial determining whether surgical decompression before radiotherapy or chemotherapy improves the ultimate results. The prognosis for functional recovery and survival are relatively good, in contrast to the bleak prognosis for most patients with metastatic carcinoma. Our patient underwent surgical decompression followed by eight courses of chemotherapy using ABVD alternating with MOPP, followed by radiation therapy and remains free of disease one and a half years following presentation.

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Prepared by: G. Morrison Henry, M.D., is in private practice and is affiliated with Neurology Associates in Little Rock.

Prepared by: Anthony Bucolo, M.D., is in private practice Hematology-Oncology in Little Rock.

Editor: David Harshfield, M.D., chief of the radiology service at the Veterans Administration Hospital in Little Rock.

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Clarke, James S.
Condrey, Yoland M.
Cook, James T.
Douglas, Donald S.
Dunbar, James C. #
Dyer, William
Dykstra, Peter C.
Guenther, John F.
Hardin, Philip R.
Johnson, Stacey M.
Kelley, Lawrence A.
Kerr, Robert L.
Knox, Thomas E.
Landrum, William
MacKercher, Peter A.
Marx, Douglas
Massey, James Y.
McGaughey, Allen S.
Rigler, Wilson F.
Roberts, David H.
Sneed, John W. Jr.
Stahl, Ray E. Jr.
Sward, David T.
TerKeurst, John

Trager, Marc
Tullis, Joe M.
Turner, Frederick C.
Webb, E. Russell
Wells, Gary
Wilbur, Paul F.
Wilson, Jack C.

Benton County

Adams, Frank
Addington, Alfred R.
Adrian, James A.
Allen, L. Barry
Allen, William M.
Arkins, James
Atkinson, Thomas
Ball, Eugene H.
Becton, Paul Jr.
Benjamin, George
Bledsoe, James H.
Boozman, Fay W. III
Carrington, Patrick
Clemens, R. Dale
Clower, John D.
Cohagan, Donald L.
Cole, Randall E.
Compton, Neil E.
Costaldi, Mario E.
Cox, Thomas
Dang, Minh-Tam
Diacon, W. Lindley
Donnell, Robert W.
Drange, R. Kirk
Elkins, James P.
Fioravanti, Bernard L.
Garrett, David C. III
Goss, Stephen
Hales, David
Harmon, Harry M.
Henderson, Oscar L.
Hiitt, Jerry L.
Hof, C. William
Hoffman, Carl E.
Holder, Robert E.
Horner, Glennon A.
Howard, K. Lamar
Howard, Willard H. Jr.
Hull, Robert R.
Huskins, James D.
Huskins, John A.
Jacks, John W.
Jennings, William E.
Kendrick, Carl M.
Knapp, James R.
Martin, Albert Jr.
McCollum, Edward
McKnight, William D.
Miles, Richard W.
Moose, John I.

Mullins, Neil D.
Neaville, Gary A.
Panettiere, Frank J.
Pappas, John J.
Pearson, Richard N.
Pickens, James L.
Platt, Michael R.
Puckett, Billy J.
Reese, Michael C.
Ritz, Ralph C.
Robbins, Robert H.
Rollow, John A.
Rolniak, Wallace A.
Steadman, Hunter M. Jr.
Sinnott, Charles H.
Stinnett, Scott G.
Stolzy, Sandra
Summerlin, William
Swain, Terry J.
Swindell, William G.
Townsend, Michael
Treptow, Douglas
Turley, Jan T.
Waldon, Gene B.
Warren, Grier D.
Weaver, Donald D.
Weaver, Robert H.
Webb, William
Wilkerson, Danny
Wright, Larry D.
Youngblood, Thomas

Boone County

Ashford, Walter P.
Bell, Thomas Edward
Bennett, Chris
Bennett, Joe D.
Brandon, Henry
Carter, J. Brad
Chambers, Carlton L. III
Crider, James T.
Daniel, Charles D.
Dunaway, Geoffrey
Ferguson, Noel F.
Fowler, Ross E.
Garland, William J. Jr.
Gladden, Jean C.
Hoferock, Thomas R.
Hudson, William A. #
Hutcheson, Galen
Kim, Hyewon
Kirby, Henry V.
Klepper, Charles R.
Kuharich, Richard M.
Langston, Robert H.
Laule, Alice R.
Ledbetter, Charles A.
Mahoney, Paul L. Jr.
Miller, Robert Jr.

Rozeboom, Victor A.
Scroggins, Sam J.
Simpson, Thomas J.
Smith, H. Van
Troupe, John T.
Vowell, Don R.
Williams, Rhys A.

Bradley County

Chambers, F. David
Marsh, James W.
Pennington, Kerry F.
Schultz, Wayne H.
Wharton, Joe H.
Wynne, George F.

Carroll County

Card, Shannon R.
Finrock, William
Flake, William K.
Kresse, Gregory
Martinson, Alice
Spurgin, Randal Truman
Stensby, Harold F.
Taylor, Richard L.
Wallace, Oliver

Chicot County

Berry, Danny T.
Burge, John P.
DeRamos, Agapito Y.
Heder, Guy W.
Kuiper, Gregory
Russell, John R.
Smith, Major E.
Thomas, H. W.
Tuangsithanon, T.
Tvedten, Tom
Vogel, Wrede E.
Weaver, William J.
Wilson, Thomas C.

Clark County

Anderson, P. R.
Balay, John W.
Hagood, Noland Jr.
Lowry, James
McLeod, Kevin
Parsons, V. Earl Jr.
Peeples, George R.
Studdard, Daniel
Taylor, George D.
Toombs, Vernon L.

Cleburne County

Baldrige, Max
Barnett, James C.
Barnett, Michael

Beasley, Harold
Campos, Amador
Eans, Thomas L.
Ewing, Jon R.
Murry, J. Warren
Poff, Joseph H.
Poff, Nathan L.

Columbia County

Alexander, John E. Sr.
Alexander, John E. Jr.
Antoon, Patrick D.
Baldwin, Ronald L.
Evans, Matthew L.
Farmer, John M.
Griffin, Rodney L.
Hawley, James Wesley Jr.
Hunter, Robert W. Jr.
Kelley, Charles W.
McMahan, H. Scott
Murphy, Fred Y.
Parkman, Robert L. Jr.
Pullig, Thomas A.
Roberts, Franklin D.
Ruff, John L.
Strange, Vance M.
Walker, Jack T.
Weber, Charles

Conway County

Hickey, Thomas H.
Lipsmeyer, Keith M.
Owens, Gastor B.
Petit, Carl
Rozzell, Allen R.
Wells, Charles F.

Craighead-Poinsett County

Alston, Herman D.
Anderson, Charles
Aston, J. Kenneth
Austin, Lester K. Jr.
Ball, John
Barker, Charles
Bartlett, Sylvan
Basinger, James W.
Berry, Donald M.
Blachly, Ronald J.
Blanchard, Steven
Blaylock, Jerry D.
Bodeker, Larry J.
Brown, Mark C.
Buckner, John H.
Burns, Richard G.
Camp, Michael
Carpenter, Kennan
Clopton, Owen H. Jr.
Cohen, Robert S.
Cone, John
Cook, John
Cranfill, Ben
Cranfill, General L. III.
Crawley, Michael E.
Degges, Russell D.
Dickson, Glenn E.
Eddington, William R.
Emerson, Steven
Felts, Larry S.
Fields, Brad
Forestiere, A. J.
Frey, Robert D.

Garner, William L.
George, F. Joseph
Golden, Stephen C.
Gossett, Clarence E.
Goza, Gary R.
Green, William
Guinn, Donald R.
Hall, Ray H. Jr.
Hiers, Connie L.
Hightower, Michael D.
Hill, Roger D.
Hogue, Ernest L.
Hubbard, William S.
Isaacson, Michael L.
James, Frank M.
Jennings, R. Duke
Jiu, John B.
Johnson, Larry H.
Johnson, Roehl W.
Jones, K. Bruce
Jones, R. J.
Jordan, Harry J.
Keisker, Henry W.
Kemp, Charles E.
Kroe, Donald J.
LaCour, Edmund
Landry, Robert J.
Lassonde, Robert G.
Lawrence, Robert O. Jr.
Ledbetter, Joseph W.
Lepore, Diane G.
Lcvinson, Mark
Lunde, Stephen P.
Lyons, Lewis C.
Mackey, Michael
Maglothin, Douglas L.
Mahon, Larry E.
McDaniel, Craig A.
Mitchell, George E.
Modelevsky, Aaron C.
Montgomery, Earl W.
Moore, Steven M.
Nash, Jerry
Nixon, D. Allen Jr.
Owens, Ben Jr.
Peacock, Lovrd
Peeler, Malcolm O.
Porter, Revel D.
Price, Edwin F.
Price, Herbert H. III
Pyle, David
Rainwater, W. T.
Raney, Bascom P.
Robbins, Robert A.
Roberts, Randy D.
Robinette, James M.
Rogers, James F.
Rusher, Albert H. Jr.
Ryals, Rickey O.
Sanders, James W.
Sapiro, Gary S.
Saunders, Earnest
Savage, Patrick Joseph
Schrantz, James L.
Schweitzer, Terri
Scriber, Ladd J.
Shanlever, Rufus C.
Shanlever, William T.
Silas, David
Skaug, Phyllis
Skaug, Warren A.

Smith, Bob W.
Smith, Floyd A. Jr.
Smith, Vestal B.
Souther, Susan
Sparks, Barrett
St Clair, John T. Jr.
Stainton, Joseph C.
Stainton, Robert M. Jr.
Stallings, Joe H. Jr.
Stevenson, Richard
Stewart, Mark
Stripling, Mark C.
Swingle, Charles G.
Taylor, Robert D.
Tedder, Michael E.
Teply, Joseph F.
Thomas, J. Fred
Tonymon, Kenneth
Tuck, Rebecca
Utey, Phillip M.
Verser, Joe
Vines, Troy Alan
Vollman, Don B. Jr.
Webb, James W.
White, Anthony T.
Wiggins, H. Lynn
Williams, E. Walden
Wilson, Joe T. Jr.
Wisdom, Garland Durwood
Woloszyn, John
Woodruff, Stephen O.
Yates, Robert L.
Young, S. Morris
Young, William C. Jr.

Crawford County

Darden, Lester R.
Edds, Millard C.
Edwards, Henry N.
Harford, Martin
Hefner, David P.
Jennings, Charles A.
Kale, Robert
Ross, R. Wcndell
Sasser, L. Gordon III
Shearer, Francis E.
Sills, D. Bart
Suthoff, James
Travis, A. Lawrence

Crittenden County

Adler, Justin Jr.
Arnold, Sidney W.
Bryant, Glen E.
Clemons, Mark
Deneke, Milton D.
Evans, Loraine J.
Ferguson, Scott
Ferguson, T. Murray
Ford, Robert C. Jr.
Hamilton, Ralph B.
Hcmandcz, Jacinto
Herrington, C. G. Cap Jr.
Hodges, John M.
Huffstutter, Paul J.
Jay, Gilbert D. III
Kennedy, Keith B.
L'Heureux, Guy J.
Lubin, Milton
McCalla, Mary
Meredith, Samuel G. Jr.

Miller, James L.
Nadeau, Kenneth R.
Peeples, Chester W. Jr.
Pierce, Trent P.
Schoettle, Glenn P.
Schoettle, Steve P.
Shrader, Floyd R.
Smith, Bedford W.
Smith, Mark M.
Utey, L. Thomas
Wah, John
Webb, Dan W.
Westbrook, H. Wade
Wright, William J.

Cross County

Beaton, James
Beaton, Kenneth E.
Bethell, Robert D.
Burks, Willard G.
Crain, Vance J.
Hayes, Robert A. Jr.
Jacobs, James R.
Young, John H.

Dallas County

Davis, Paul
Delamore, John H.
Dobson, Jack T.
Howard, Don
Moran, Paul
Nutt, Hugh A.

Desha County

Go, Peter Kong Hua
Harris, Howard R.
Hoagland, Robert A.
Masquil, Filipe
Robinson, Guy U.
Tumey, Lonnie R.

Drew County

Binns, Van C. #
Busby, Arlee K.
Maxwell, Ralph M.
McKiever, William R.
Oxner, Troy Wayne
Wallick, Paul A.
Wilson, Harold F.

Faulkner County

Archer, Charles A. Jr.
Beasley, Margaret D.
Benafield, Robert B.
Bowlin, Randal
Daniel, Sam V.
Furlow, William C.
Garrison, James S.
Ghormley, Jonathan
Gordy, L. Fred Jr.
Hendrickson, Richard O. Jr.
Hilman, Michael G.
Horton, Charles
Jackson, Carole
Magic, Jimmie J.
Marvin, Peter
McCarron, Robert
McChristian, Paul L.
Murphy, Kenneth
Shirley, David C.

Smith, John D.
Smith, Lander A.
Stancil, Vicki
Stone, Phillip
Throneberry, Bart

Franklin County

Gibbons, David L.
Long, C. C.
Smith, John C.
Wilson, Robert

Garland County

Arthur, James M.
Aspell, Robert
Atherton, Lee G.
Atkinson, Robert H.
Bandy, Preston R.
Beamer, Lee F.
Bodemann, Michael C.
Bodemann, Stephen L.
Bohnen, Loren O.
Borg, Robert V.
Bracken, Ronald J.
Braley, Richard E.
Braun, James R.
Brunner, John H.
Bumpas, Timothy F.
Burton, Frank M.
Burton, James F.
Campbell, James W.
Cates, Jack A.
Chamberlain, Joe W.
Cofcr, Thomas
Crabtree, John H.
Cupp, Cecil W. III
Davis, Sheryl L.
Dembinski, T. Henry
Dodson, John W. Jr.
Dunn, Richard W.
Durham, Thomas M. Jr.
Eisele, W. Martin
English, P. Timothy
Finan, E. Michael
Fore, Robert W.
Fotioo, George J.
French, James H.
Gardial, J. Richard
Gardner, James L.
Garner, Onyx P.
Gocio, Allan C.
Griffin, James E.
Haggard, John L.
Harper, Edwin L.
Headrick, Daniel
Hecchanova, D. M. Jr.
Heinemann, Fred M.
Hill, Robert L.
Hollis, Thomas H.
Howe, H. Joe
Humphreys, Robert P.
Irwin, William G.
Jackson, Haynes G.
Jayaraman, K. K.
Jayaraman, Vilasini D.
Jayasundara, Naomal S.
Johnson, Paulette S.
Johnson, Robert D.
Johnston, Gaither C.
Kaler, Ron A.
Kcadle, William R.

Kincheloe, A. Dale
King, Leeman H.
Kleinhenz, Robert W.
Klugh, Walter G. Jr.
Koehn, Martin A.
Krishnan, Bhaktan
Lang, Patricia A.
Larrison, Charles A.
Lee, William R.
Lewis, Robert L.
Lovell, Clarence R.
Madsen, Henrik II
Maruthur, Gopakumar
Mashburn, William R.
McConkie, Stuart
McCrary, Robert F. Jr.
McFarland, Louis R.
McMahan, James
Mcek, Gary N.
Munos, Louis R.
Newton, Doane M.
Pai, Balakrishna
Pappas, Deno P.
Parkerson, Cecil W.
Peeples, Raymond E.
Pellegrino, Richard
Powell, Brenda
Qucen, George P.
Rainwater, W. Sloan
Reddy, Prabhakara K.
Robert, Jon M.
Robertson, Fred T.
Rosenzweig, Joseph L.
Russell, Mark
Sanders, Hallman E.
Schmidt, Clinton C.
Seifert, Kenneth A.
Shelby, Eugene M.
Shroff, Rajesh K.
Simpson, John B.
Slaton, Catherine R.
Slaton, G. Don
Slezak, James
Smith, Bruce L. Jr.
Smith, John
Smith, Phillip L.
Sorrels, John W.
Springer, Melvin R. Jr.
Springer, William Y.
Stecker, Elton H. Jr.
Stecker, Rheeta M.
Stough, Dowling B. IV.
Stough, Dowling Bluford III.
Thomas, W. Al
Thompson, Thomas P. Jr.
Trieschmann, John W.
Tucker, R. Paul
Wade, H. King Jr. #
Wallace, Thomas
Walley, Luther R.
Ward, David
Webb, Timothy
Woodward, Philip A.
Wright, Charles C.
Wright, William J.
Wyatt, Richard A.

Grant County

Irvin, Jack M.
Paulk, Clyde D.

Greene-Clay County

Baker, A. J.
Baker, Clark M.
Boggs, Dwight F.
Bonner, J. Darrell
Cagle, Roger E.
Collier, George H. Jr.
Crow, Asa A.
Duckworth, Hillard R.
Futrell, Junius B.
Hardcastle, R. Lowell
Harper, Bland
Hazzard, Marion P.
Hobby, George A.
Kemp, Clarence
Lawson, J. Larry
Martin, Richard O.
Mitchell, Bennie E.
Muse, Jerry L.
Page, Billie C.
Purcell, Donald I.
Sellars, John R.
Shedd, Leonus L.
Sheridan, James G.
Shotts, C. Mack Jr.
Shotts, Vem Ann
Watson, Samuel D.
White, Robert B.
Williams, Dwight M.
Williams, Jacob M.

Hempstead County

Branch, James W. Sr.
Harris, Lowell O.
Holt, Forney G.
Martindale, James G. #
McKenzie, Jim
Portis, Richard P.
Stevens, David G.
Wright, George H.

Hot Spring County

Bollen, A. Ray
Brashears, Larry B.
Burton, Bruce K.
Cobb, Russell W.
Ellis, C. Randolph
Highsmith, Vivian F.
Kerish, N. B.
Lloyd, Gregory M.
Peters, Claude F.
Vaughan, John A.
White, Bruce A.
White, Robert H.

Howard-Pike County

Dunn, Robert
Floyd, Mark A.
Gullett, A. Dale
Hearnsberger, John E.
Humphreys, T. J. Jr.
King, Joe D.
O'Bryan, Deborah
Peables, Samuel W.
Sykes, Robert
Turbeville, James O.
Ward, Hiram T.
White, Phillip L.

Independence County

Alexander, Steve
Allen, James D.
Baker, John R.
Baker, Robert V.
Baxley, Paul J.
Beck, Carl T.
Bess, Lloyd G.
Brown, Verona T.
Davidson, Andy
Davidson, Dennis O.
Fowler, William
Fulbright, Thomas
Garst, Neema A.
Garst, Steven
Goodin, William H. Jr.
Hays, Sarah F.
Jones, Edward J.
Jones, Edward T.
Ketz, Wesley J.
Lambert, John S.
Luter, Dennis W.
Lytle, Jim E.
McClain, Charles M. Jr.
Moody, Lackey G.
O'Brien, Marcus D.
Piediscalzi, Nicholas
Raney, W. Troy
Scott, John G.
Simpson, Ronald
Slaughter, Bob L.
Sloan, Fredric J.
Smith, Bob G.
Stalker, James M.
Strickland, Nathan E.
Sutterfield, Terry F.
Taylor, Chaney W.
Taylor, Charles A.
Tucker, Charles L.
Waldrip, William J. III
Walton, Robert B.
Zini, James E.

Jackson County

Ashley, John D. Jr.
Carney, J. W.
Chauhan, Mufiz A.
Conrady, Rickie A.
Dudley, Guilford M. III
Foote, John W.
Frankum, Jerry M. Jr.
Green, Roger L.
Hergenroeder, Paul J.
Jackson, Jabez Fenton Jr.
Junkin, A. Bruce
Lopez, Ramon E.
Poon, Hon K.
Reynolds, Roland C.
Williams, Thomas E.
Young, Jack S. III

Jefferson County

Anderson, Charles W.
Anderson, Daphne
Anderson, Mark
Armstrong, Simmie Jr.
Atkinson, Evangelina
Atkinson, Robbie
Atnip, Gwyn
Attwood, H.
Bell, Carl H. Jr.

Bennett, John
 Bennett, Keith
 Blackwell, Banks
 Bracy, Calvin M.
 Brooks, R. Teryl Jr.
 Buckley, J. Wayne
 Burford, Thomas G.
 Bums, Robert E.
 Busby, John
 Butler, Robert C.
 Campbell, James C. Jr.
 Carlton, Irvin L.
 Cheek, Ben H.
 Clark, James F. Jr.
 Coker, L. Randle
 Crenshaw, John
 Davis, Charles M.
 Dedman, John D.
 Deneke, William
 Duckworth, Thomas S.
 Estes, D. Scott
 Fendley, Claude E.
 Fendley, Herbert F.
 Flowers, Martha A.
 Forestiere, Lee A.
 Freeman, William H.
 Frigon, Gary F.
 Frigon, Jacquelyn S.
 Glasscock, Robert E.
 Green, Horace L.
 Gullett, Robert R. Jr.
 Hardin, J. David
 Harper, William F.
 Hegwood, H. Melvin
 Henderson, Francis M.
 Hughes, L. Milton
 Hussain, Shafqat
 Hutchison, E. L.
 Hyman, Carl E.
 Irwin, Raymond A. Jr.
 Jacks, David C.
 Jacks, Dennis
 James, William J.
 Jenkins, Bobby
 Jenkins, Mary Ellen
 Joseph, Aubrey S.
 Justiss, Richard D.
 Khan, Mahmood A.
 King, Yum Y.
 Langston, Lloyd G.
 Ligon, Ralph E.
 Lim, William N.
 Lindsey, James A.
 Lum, Don
 Lupo, David A.
 Lytle, John O.
 Mabry, Charles D.
 Maynard, Ross E.
 McDonald, Robert L.
 McFarland, Mike S.
 Mehta, Shyam P.
 Meredith, William R.
 Miller, Donald L.
 Milligan, Monte C.
 Morris, Harold J.
 Nichols, William
 Nixon, David T.
 Nixon, William R.
 Nuckolls, J. William
 Pearce, Malcolm B.
 Perry, V. Bryan

Pierce, J. R. Jr.
 Pierce, Reid
 Pierce, Ruston Y.
 Rainey, William C.
 Raney, Oliver C.
 Rayford, Cleveland
 Reid, Lloyene B.
 Ridling, Anna T.
 Rittelmeyer, Clarence M.
 Roaf, Sterling A.
 Robinette, Joseph S.
 Rogers, Henry L.
 Ross, Robert L.
 Samuel, Ferdinand K.
 Shorts, Stephen D.
 Simmons, Calvin R.
 Simpson, P. B. Jr.
 Smith, Paul L.
 Stem, Howard S.
 Sullenberger, A. G.
 Sweatt, John
 Tanner, Ronald D.
 Tisdale, Alfred D. Jr.
 Toatley, Donald U.
 Townsend, Thomas E.
 Tracy, C. Clyde
 Waheed, Atiya N.
 Walajahi, Fawad H.
 Washington, Erma
 Wilkins, Walter J. Jr.
 Wineland, Herbert L.
 Worrell, Aubrey M. Jr.

Johnson County

Boswell, Clifford A.
 Goodman, James David
 McAuley, John R.
 Pennington, Donald H.
 Shrigley, Guy P.

Lafayette County

Hutson, Sanford E. III
 Lee, Willie J.

Lawrence County

Hughes, Joe E.
 Joseph, Ralph F.
 Lancaster, Ted S.
 Langley, Michael G.
 Quevillon, Robert D.
 Spades, Sebastian A. III

Lee County

Balke, Susan W.
 Fields, E. C.
 Gray, Dwight W.
 Ly, Duong N.

Little River County

Armstrong, James
 Dalby, Robert D.
 Peacock, Norman W. Jr.
 Shelton, Joseph Jr.

Logan County

Buckley, Douglas A.
 Chalfant, Charles
 Daniel, William R.
 Enns, Wayne P.
 Harbison, James D.

Parker, Chuck
 Roberts, William J.
 Smith, James T.
 Ulrich, Guy
 Williams, John R.

Lonoke County

Abrams, Joe A.
 Anderson, Leslie
 Braswell, Thomas
 Chapman, Jerry C.
 Elam, Garrett
 Gartman, Joseph F.
 Holmes, Byron E.
 Inman, Fred C. Jr.
 Schumann, Gerald M.
 Washburn, C. Yulan

Miller County

Andrews, A. E. Jr.
 Barnes, Walter C. Jr.
 Blankenship, D. Michael
 Brown, Sam F.
 Burroughs, James C.
 Collins, Stanley
 Cummins, J. Craig
 Cutler, Otis
 Deskin, Roy L.
 Dildy, Edwin V. Jr.
 Ditsch, Craig E.
 Dobbs, Michael
 Dodd, N. Leland
 Dodge, John M.
 Duncan, Donald L.
 Fisher, John
 Fournier, Donald C.
 Gabbie, Mark
 Gillean, John A.
 Graham, John
 Hall, Eric E.
 Hall, Jon D.
 Harrell, William B. Jr.
 Harris, C. Lynn
 Hillis, Thomas M.
 Hodson, Gregory
 Hughes, A. Kcith
 Hughes, R. Paul
 Hutcheson, Fred A. Jr.
 Jean, Alan B.
 Jones, John W.
 Joyce, Frederick E.
 Kcmp, Karlton H.
 Kittrell, James
 Knowles, Stanley C.
 Lcavalle, Ray W.
 Loe, Arlis W.
 McGinnis, Robert S. Sr.
 Meredith, Paul D.
 Morris, Howard
 Newton, Norris L.
 Newton, Norris L. Jr.
 Norris, John A.
 O'Banion, Dennis
 Payne, Alvin
 Pecbles, Larry M.
 Ridout, Robert M. Jr.
 Robbins, Joseph
 Rountree, Glen A.
 Royal, Jack L.
 Schmidt, Howard
 Shipp, G. Carl

Smith, Amett D. Jr.
 Solomon, J. Alan
 Somerville, Patrick J.
 Stringfellow, Jerry B.
 Tompkins, William Jr.
 Vereen, Lowell E.
 Wade, Billy
 Warren, William Jr.
 Wilhelm, Frieda
 Wren, Herbert B.
 Wright, James O. III
 Yarbrough, Charles P.
 Young, Mitchell

Mississippi County

Abraham, Anes Wiley
 Abramson, Lawrence
 Bell, Mary C.
 Biggerstaff, Jerry
 Brock, Charles C. Jr.
 Campbell, Charles E. Jr.
 Cole, Cecil R.
 Cullom, Sumner R.
 Fairley, Eldon
 Fergus, R. Scott
 Hall, Leslie
 Haynes, Max G.
 Hester, Karen Calaway
 Hester, Richard
 Higley, George B. Jr.
 Hubener, Louis F.
 Hudson, James H.
 Husted, G. Scott
 Johnson, Jonathan H.
 Jones, Herbert
 Jones, Joseph V.
 Melton, Clinton G.
 Osborne, Merrill J.
 Oster, Catherine J.
 Pollock, George D.
 Rauls, Stephen R.
 Rhodes, Joseph
 Rhodes, R. F.
 Rodman, T. N.
 Russell, James D.
 Sammons, L. C. Jr.
 Shaneyfelt, E. A.
 Smith, Ronald D.

Monroe County

Collins, Linda
 David, Neylon C. Jr.
 Pham, Dac Tat
 Pupsta, Benedict F.
 Stone, Herd E. Jr.
 Walker, Walter L.

Nevada County

Crow, H. Blake #
 Vermont, Charles

Ouachita County

Braden, Lawrence F.
 Brunson, Milton
 Crump, Mark
 Dedman, J. L. Jr.
 Dedman, William D.
 Fohn, Charles H.
 Forward, Robert B.
 Guthrie, James

Hout, Judson N.
 Jameson, John B. Jr.
 Kendall, Jerry R.
 McFarland, Gale
 Miller, John H.
 Nunnally, Robert H.
 Oznent, L. V.
 Sanders, Cal R.
 Thorne, Arthur E.

Phillips County

Barrow, John H. Jr.
 Bell, L. J. Patrick
 Bell, L. J. Patrick II
 Berger, Alfred A.
 Duensing, Theodore
 Elovitz, Maurice J.
 Faulkner, Henry N.
 Frederick, William Ronald
 Greening, Billy
 Kirkman, C. M. T.
 McCarty, Charles P.
 McCarty, Gordon E. Jr.
 McDaniel, Marion A.
 Miller, Robert D. Jr.
 Paine, William T.
 Patton, Francis M.
 Rangaswami, Narayanaswami
 Robirds, David Mark
 Vasudevan, Kanaka
 Vasudevan, P.
 Wise, James E. Jr.

Polk County

Finck, John Henry
 Fried, David D.
 McClard, Helen
 Mesko, John D.
 Rogers, Henry N.
 Wood, John P.

Pope County

Ashcraft, Ted
 Austin, Nathan
 Bachman, David S.
 Barron, William G.
 Barton, A. Dale
 Battles, Larry D.
 Beavers, Kevin
 Bell, Michael
 Berner, Dennis W.
 Birum, Patricia J.
 Bost, R. Kingsley
 Bradley, Stanley C.
 Brown, Charles H.
 Burgess, James G.
 Callaway, Jody C.
 Carter, James M.
 Cloud, Joe A.
 Crumpler, Joe B. Jr.
 Dunn, Donald L.
 Ferris, Craig
 Galloway, William W.
 Haines, Lynn
 Harrison, Rick
 Hendren, Mike
 Henry, J. Arnold
 Hill, Donald F.
 Hollabaugh, Denise
 Honghiran, Ted
 Kerin, Douglas

Killingsworth, Stephen M.
 King, John W.
 King, W. Ernest Jr.
 Kolb, James M. Jr.
 Lahr, Charles H.
 Lane, Walter H. Jr. #
 Lawrence, Frank M.
 Lovell, Richard K. Sr.
 Lowrey, Douglas H.
 Lyford, Joe H. Jr.
 Malone, George E.
 Mauch, E. Jane
 May, Robert H. Jr.
 Meyer, Kelly H.
 Mobley, Max J.
 Monfee, Andrew M.
 Myers, J. Mark
 New, Kenneth O.
 Patterson, William D.
 Riddell, C. Michael
 Riley, Don C.
 Speed, Darrell
 Stolz, Gerald A. Jr.
 Teeter, Stanley D.
 Thurlby, W. Robert
 Turner, Finley P. II
 Wilkins, Charles F. Jr.
 Williams, David M.
 Young, Sandra S.

Pulaski County

Abbott, William W.
 Abel, Lee C.
 Abraham, James H.
 Abraham, Robert E.
 Adametz, James
 Adametz, John
 Adamson, James
 Alford, T. Dale
 Allen, Durward Jr.
 Allen, John E. Jr.
 Allen, Thomas
 Alston, Phillip
 Aquino, Al
 Araoz, Carlos
 Armstrong, Howard
 Arnold, David
 Arrington, Robert
 Ashcraft, Keith
 Atkinson, William Jr.
 Ault, Charles C.
 Austin, R. Lee
 Autry, Daniel H.
 Baber, John C. Jr.
 Baber, John T.
 Backus, Joe T.
 Bailey, H. A. Ted Jr.
 Baker, Glen F.
 Baker, John
 Baker, Johnson
 Baker, Susan W.
 Baker, Yvette
 Baldwin, Maxwell R.
 Ball, Charles W. Jr.
 Ballard, Clarence E. Jr.
 Barber, Jeffrey
 Barclay, David
 Bard, David S.
 Barger, Denver L.
 Barlow, Brian E.
 Barnes, Reginald

Barnes, Robert W.
 Barnett, David
 Barnett, Troy F.
 Barron, Edwin N. Jr.
 Bates, Ramona
 Bates, Stephen
 Batres, Francisco
 Bauer, F. Michael
 Bauer, Frank M. Jr.
 Bauman, David C.
 Beadle, Beverly
 Bearden, James R.
 Beaton, J. Neal
 Beck, Joseph II.
 Becquet, Norbert J.
 Belknap, Melvin L.
 Bennett, Eaton W.
 Bennett, F. Anthony Jr.
 Berry, Frederick B.
 Berry, Robert L.
 Bevans, David W. Jr.
 Bienvenu, Gregory
 Billie, James
 Biondo, Raymond V.
 Birkett, Ian McRae
 Bishop, William B.
 Black, H. Thurston
 Black, Hal R. Jr. #
 Blackshear, Jack L. Jr.
 Blankenship, William F.
 Blasier, R. Dale
 Boehm, Timothy
 Boellner, Samuel W.
 Boger, James E.
 Bogost, Bruce
 Boop, Warren C. Jr.
 Bornhofen, John H.
 Bost, Roger B.
 Bowen, William
 Boyd, Charles M.
 Boyle, Ronald H.
 Bozeman, Barbara J.
 Bradburn, Curry B. Jr.
 Bradley, Joe F.
 Brainerd, Jay O.
 Brenner, George H. Jr.
 Bressinck, Renie E.
 Brimberry, Ronald K.
 Brinkley, Roy A.
 Brizzolara, A. J.
 Brizzolara, John Paul
 Broach, R. Fred
 Brown, Michael
 Brown, Pamela
 Brown, Scott H.
 Browning, Donald G.
 Browning, Stanley K.
 Brunson, Ashley
 Bryant, Deborah M.
 Buchanan, Francis R.
 Buchanan, Gilbert A.
 Buchman, Joseph A.
 Buchman, Joseph K.
 Bucolo, Anthony P.
 Budhraj, Meenakshi
 Buford, Joe L.
 Bumpas, Joe H.
 Burger, Robert A.
 Burnett, Hugh F.
 Burnham, William W.
 Burrow, Dennis R.

Byrd, Lucas M. Jr.
 Byrum, Jerry
 Calcote, Robert A.
 Calhoon, J. Dale
 Calhoun, Joseph D.
 Calhoun, Richard A.
 Campbell, Gilbert S.
 Campbell, James W.
 Caplinger, Kelsy J. III
 Carfagno, Jeffrey
 Camahan, Robert G.
 Carson, Layne E.
 Carter, Jerry L.
 Caruthers, Samuel B. Jr.
 Casali, Robert E.
 Cash, Darlene
 Casper, Robert B.
 Cathey, Janet
 Cathey, Steven
 Cavin, Lillian
 Chakales, Harold H.
 Chandler, Billy M.
 Chappell, Carol W.
 Cheairs, David B.
 Cheairs, John T.
 Chisholm, Dan P.
 Choate, Robert B.
 Christeson, William W.
 Christian, John D.
 Chudy, Amail
 Church, Beresford #
 Church, Marion M.
 Church, Michael
 Clark, Richard B.
 Clift, Steven A.
 Clifton, Cliff
 Cobb, Jock S.
 Cockrill, H. Howard Jr.
 Cogburn, Bob E.
 Colclasure, Joe B.
 Collins, David
 Cone, John
 Corbitt, Mary
 Cornell, Paul J.
 Cosgrove, Kingsley W. Jr.
 Cosgrove, Lisa
 Craig, Marion S. Jr.
 Crawford, Cary M.
 Crews, J. Travis
 Crocker, Charles H.
 Cross, J. B.
 Crow, Joe W.
 Crow, R. Lewis Jr.
 Curtner, Bryon D.
 Davie, Melanie
 Davis, Glenn R.
 Davis, J. Lynn
 DeLoach, John Jr.
 Dean, David M.
 Dean, Gilbert O.
 Deaton, C. William Jr.
 Deer, Philip J. Jr.
 Deer, Philip James III.
 Dennis, James L.
 Denson, William D.
 DesLauriers, S. Killeen
 Dickins, John R. E.
 Dickins, Robert D. Jr.
 Dickson, D. Bud
 Dilday, James
 Dillard, Daniel C.

- Diner, Bradley
Dixon, Keith A.
Dodd, Doyné
Dodge, Eva F. #
Doucet, Marlon J.
Douglas, Warren M.
Downs, Ralph A.
Dungan, William T.
Dwyer, Gregory A.
Easley, Edgar J.
Easter, Rex M.
Edge, Otis H.
Edmiston, Frank G.
Eidt, John
Eisenach, R. Jeffrey
Eisner, Richard A.
Elders, M. Joycelyn
English, Jim
Evans, Billy
Evans, Scott J.J.
Eyre, Byron L.
Farmer, Joseph F.
Farque, Greg L.
Farris, Guy R. Jr.
Fazekas-May, Mary
Fernandez, Agustin
Ferris, Ernest J.
Fewell, Ronald D.
Fielder, Charles R.
Fields, Patrick R.
Finan, Barre F.
Fincher, Robert L.
Finkbeiner, Alex E.
Fiser, Martin
Fiser, Robert H. Jr.
Fiser, William P. Jr.
Fisher, Robert A.
Fitzgerald, Charles
Fitzhugh, A. Stuart
Flack, James V. Jr.
Flanigan, Stevenson
Flanigan, William
Fletcher, Anthony
Fletcher, Elizabeth D.
Fletcher, Thomas M.
Flippin, Tony A.
Florez, James P.
Floyd, Bill G.
Fraiser, Lacy P.
France, Gene L.
Franklin, Gregory
Fraser, Eric A.
Fraser, James H. Jr.
Frazier, Cynthia
Frazier, George T.
Fuller, C. Dale
Fuller, C. James III
Fulmer, John M.
Galbraith, Robert C.
Gardner, Guy F.
Gettys, Joseph M. Jr.
Gibbs, Mark
Gibson, Gordon L.
Giglia, Anthony R. III
Giles, Wilbur M.
Gillespie, A. Tharp
Gillespie, James
Gilliam, David
Glenn, Wayne B.
Glidden, Michael L.
Glover, Lawson E. Jr.
- Glover, W. Clyde
Golden, William E.
Good, Henry H.
Gordon, Vida H.
Gosser, Bob L.
Goza, George M. Jr.
Graham, G. Grimsley
Granger, William III
Grant, Karen G.
Gray, Edwin F.
Green, Benny J.
Green, William O. III
Greenway, C. Don
Greer, Gerald S.
Greutter, John E. Jr.
Griebel, Jack A. Jr.
Grimes, H. Austin
Growdon, James H.
Guggenheim, Frederick G.
Guin, Jere D.
Gustavus, John L.
Hagler, James L.
Hahn, Herbert
Hall, A. D.
Hall, A. David
Hall, R. Whit
Hamilton, George Jr.
Hampton, John R. III
Hankins, Edwin III
Harber, Harley
Hardberger, R. E.
Hardin, Ronald D.
Harger, C. Harold
Hargrove, Joe L.
Harper, Ernest H.
Harper, Gary E.
Harrendorf, Cagle
Harrington, Mariann
Harris, Donald R.
Harris, T. Stuart
Harris, W. Tumer
Harrison, A. Vale
Harrison, Roy E.
Harrison, William
Harshfield, David Lee Jr.
Hawley, Harold B.
Hayden, William F.
Hayes, J. Harry Jr.
Hayes, Richard L.
Hayes, Sidney P.
Haynes, W. Ducote
Headstream, James W.
Heamsberger, H. Graves III
Heamsberger, Henry G. Jr.
Hedges, Harold I.V.
Hedges, Harold H.
Hefley, Bill F.
Hefley, William Jr.
Henker, Fred O. III
Henry, C. Reid Jr.
Henry, Charles R. Sr.
Henry, D. Andrew
Henry, G. Morrison
Henry, Guy
Henry, J. Charles
Henry, J. Forrest Jr.
Henry, Richard Y.
Henry, Robert L. Jr.
Henry, William T.
Henson, Gregory N.
Herron, Jerry M.
- Herron, John T.
Hickey, Joseph P.
Hicks, David
Hicks, David
Hixson, Marcia Lynn
Hodges, J. Timothy
Hodges, Lindy
Hodges, Steven C.
Hoffmann, Thomas H.
Holland, Jay D.
Hollenberg, Henry G.
Holloway, J. Douglas
Holmes, Harlan C.
Holt, L. Gordon
Holt, Stephen
Holton, Jerry C.
Hough, Aubrey J. Jr.
Houk, Richard
Howell, Coburn S. Jr.
Howell, Marsha T.
Hudson, Thomas F. III
Hughes, Ronald D.
Hundley, John M.
Hundley, Randal F.
Hutchins, Steven W.
Hutson, Harold G.
Jackson, J. Presley
Jackson, Morris A.
Jackson, Thomas
Jagannath, Sundar
Jansen, G. Thomas
Jefferson, Terry
Johnson, B. Richard
Johnson, Ben D.
Johnson, Dianne Flowers
Johnson, Henry D.
Johnson, Michael
Johnson, Philip H.
Johnston, Dale E.
Johnston, Thomas G.
Jones, Gail Reede
Jones, Garry L.
Jones, John C.
Jones, Kathleen C.
Jones, Robert D.
Jones, Roy
Jones, William N.
Jordan, F. Richard
Jordan, Randy A.
Joseph, Ralph F. II
Joscph, William Frank
Jouett, W. Ray
Joyce, John W.
Junkin, Ruth H.
Kaemmerling, Raymond E.
Kahn, Alfred Jr.
Kane, Francis Jr.
Kane, James J.
Keathley, Susan A.
Kceran, Michael G.
Kellar, Stanley L.
Keller, Alford W.
Kennedy, Charles H.
Kennedy, Eleanor E.
Kennedy, H. Frazier
Key, J. Michael
Kilgore, Reed W.
King, Michael T.
Kirchner, Jeffrey
Kittler, Fred J.
Kizziar, Jim C.
- Kleinschmidt, Nancy J.
Knight, Daniel
Knox, Michael F.
Kolb, Agnes J.
Kolb, W. Payton
Koonce, Thomas W.
Kovaleski, Thomas M.
Kozberg, Oscar
Krulin, Gregory S.
Kumpuris, Andrew G.
Kumpuris, Dean
Kumpuris, Frank G.
Kuykendall, R. Craig
Kyle, Joan E.
Kyser, James F.
Laakman, Robert W.
Lambert, Robert A.
Landers, James H.
Landgren, Robert C.
Lane, John W.
Lang, Nicholas P.
Langston, Harold D.
Laurenzana, Donald A.
Lawson, Mason G.
LeNarz, LeRoy A.
Lehmberg, Robert W.
Leibovich, Marvin
Leonard, Donald G.
Leou, Frank J.
Lester, Roger
Lewis, Derek
Lewis, Laurie W.
Lewis, W. Sexton
Lile, Henry A.
Lincoln, Ben M.
Lipke, Jay M.
Loebl, Edward C.
Logan, Charles W.
Love, Tommy L. Jr.
Lowe, Betty A.
Lucy, Dennis D. Jr.
Ludwig, Frank R.
Lyons, Virgle E. Jr.
Mabrey, William
Magie, Stephen K.
Malak, F. A.
Mallory, John A.
Maloney, F. Patrick
Maners, Ann
Mann, R. Jerry
Markland, Gary S.
Marks, Stephen R.
Martin, Kenneth A.
Martin, Richard H.
Martin, Robbie
Mason, J. Zachary
Mason, William L.
Matthews, Joseph W.
Matthews, Robert R.
McAdoo, Hosea W. Jr.
McCarthy, Richard E.
McCluer, Shirley M.
McConnell, John D.
McCracken, Gail Ann
McCracken, John
McCrary, George A.
McCutcheon, Frank B. Jr.
McDonald, James E.
McDonald, Judy
McDonald, William Glen
McFarland, Cortez

McGowan, Robert Jr.	Padilla, Fernando	Seibert, Joanna J.	Teplick, Steven
McGrew, Robert N.	Pappas, James J.	Seibert, Robert	Texter, E. Clinton Jr.
McGriff, Lloyd	Parker, J. Mayne	Selakovich, Walter G.	Thomas, A. Henry
McKelvey, K. David	Parkhurst, James	Selby, John H. Jr.	Thomas, Jerry L.
McKinney, Carl	Parmley, Tim	Shannon, Robert F.	Thomas, Kathy
McKnight, C. Allen	Parnell, Clifton L. III	Shock, John P.	Thomas, Peter O.
McMillin, F. Lamar Sr.	Paulus, Thomas E.	Short, Harold K.	Thompson, A. Reed
McNair, James R.	Pearce, Charles	Shotts, Joseph	Thompson, Dola S.
McNee, Valerie	Peeples, R. Earl	Silvoso, Gerald R.	Thompson, John R.
Meacham, Donald F.	Peters, John E.	Simmons, Orman W.	Thompson, S. Berry Jr.
Meador, Annette Parker	Peters, Phillip J.	Simpson, N. Henry Jr.	Thompson, Steven M.
Means, Paul N.	Petursson, Gissur J.	Sims, James M.	Thom, G. Max
Mellor, Roy II	Phillips, Bert L.	Singer, Peter	Tilley, Steve
Mendelsohn, Lawrence A.	Phillips, Charles E.	Singleton, L. Gene	Towbin, Eugene J.
Metrailler, James A.	Phillips, James R.	Sinor, Elicia	Tracy, Phillip A.
Meziere, Tom	Pike, John D.	Sipes, Frank M.	Tranum, Bill L.
Middaugh, Riley Ann	Pledger, Norman R.	Skokos, C. Kemp	Trussell, Thomas W.
Miles, David A.	Pollard, Arlee E.	Slater, John G. Jr.	Tseng, Jyi-Ming
Miller, Forrest B. Jr.	Pope, Norton A.	Slaven, John E.	Tucker, R. Stephen
Miller, Frank C.	Porter, Robert Jr.	Slayden, John E.	Tucker, W. Everett
Miller, Raymond P. Sr.	Potts, Jerry L.	Sloan, Fay M.	Valentine, Robert G. Jr.
Milner, E. L.	Power, Robert C.	Sloan, James M.	Vaughter, W. Roger
Mitchell, George K.	Prather, Jerry L.	Smart, Douglas F.	Velez, Duane
Mizell, Walter S.	Price, Ben O.	Smelz, Johnny	Vogel, Robert G.
Moffett, Robert Jr.	Pringos, Andrew A.	Smith, Aubrey C.	Vyas, Dileepkumar R.
Money, Wandal D.	Purdy, Harold D.	Smith, Charles Jr.	Wade, William I. Jr.
Mooney, Donald K.	Pyle, Hoyte R. Jr.	Smith, David E.	Wagoner, Jack
Moore, Burton A.	Quirk, J. Gerald	Smith, Douglas B.	Walker, Ronald
Moore, J. Malcolm Jr.	Ransom, John M.	Smith, G. Richard Jr.	Walt, James R.
Moore, Michael	Raque, Carl J.	Smith, James L.	Ward, Harry P.
Moore, Rex N.	Rector, Naney F.	Smith, Mose III	Ward, Thomas
Moore, Robert B.	Reding, David L.	Smith, Purcell Jr.	Warford, Walton R.
Moore, Thomas	Redman, John F.	Smith, Thomas J.	Warren, Emory
Morris, Paula	Reed, Ewing C. Jr.	Smith, Thomas W.	Watkins, Charles J.
Morris, W. Dale	Reese, William G.	Smith, Tom	Watkins, John Jr.
Morris, Woodbridge E. #	Regnier, George G.	Somers, A. Jack	Watkins, John G. III
Morrison, Debra F.	Reid, Gene W.	Sorrells, R. Barry	Watkins, Larry S.
Morrison, James R. #	Rice, Charles	Sotomora, Ricardo F.	Watson, C. Robert
Morse, James C.	Riddle, John F. Jr.	Squire, Arthur E. Jr.	Watson, Charles
Morton, William J.	Riegler, N. W. Jr.	St Amour, Thomas E.	Watson, Daniel W.
Mulhollan, James S.	Riley, William H.	Stair, J. Michael	Weber, Edward R.
Mundie, J. Ryland	Ritchie, Robert Ross	Stallings, Walt	Weber, James R.
Murphy, Bruce	Robbins, Kenneth	Stanley, Joe P.	Weber, Michael
Murphy, James E. Jr.	Roberson, Michael C.	Stanton, T. Michael	Weiss, Gerald N.
Murphy, Joseph	Robinson, Paul F.	Steele, William L.	Welch, Samuel B. Bradley
Murphy, Randolph	Rodgers, C. Dudley Jr.	Stefans, Vikki Ann	Wellborn, James C. Jr.
Murphy, Robert	Rodgers, Charles H.	Stephens, Wanda	Wellons, James A. Jr.
Murphy, Tena	Rooney, Thomas P.	Stenberg, Jack J.	Wende, Raymond A.
Nagel, Fred G.	Rosenbaum, Carl A.	Stiles, Teresa	Wenger, Carl E.
Nash, John C.	Ross, Ashley Sloan	Stone, Van D.	Westbrook, Kent C.
Neale, David	Ross, Cynthia	Storeygard, Alan R.	Westerfield, Frank M. Jr.
Nelson, Alvah J. III	Ross, Robert W.	Stotts, John R.	White, Faber A.
Nelson, Carl L.	Ross, S. William	Stout, Kimber	White, Oba B.
Nestrud, Richard M.	Rothert, Frances C.	Strauss, Alvin W. Jr. #	Wilkes, Elbert H.
Newsom, Jon Kirby	Rounsaville, Harry L.	Strauss, Mark	Wilkes, T. David I.
Newton, Fred E.	Roy, F. Hampton	Strode, Steven W.	Williams, Alonzo D.
Nix, Richard A.	Ruggles, Dwayne L.	Stroope, George F.	Williams, C. David
Nokes, Steven	Runyan, William A.	Studdard, James D.	Williams, G. Doynce Jr.
Nolen, James E.	Rutledge, William L.	Sturdivant, Stephen	Williams, Paul E.
Norton, George A.	Saer, Edward H. III	Suen, James	Williams, Ronald N.
Norton, Joseph A.	Saltzman, Ben N.	Suliman, J. Samir	Wills, Pamela
O'Neal, Walter H.	Satre, Richard W.	Sullivan, Charles D.	Wilson, Elaine
Oates, Gordon P.	Satterfield, John V. III	Sullivan, Jan R.	Wilson, Frances C.
Oddson, Terrence A.	Schlicht, Lisa	Sundermann, Richard H.	Wilson, Frank J. Jr.
Ogden, Mahlon D.	Schock, Charles C.	Swindoll, Bryant S.	Wilson, I. Dodd
Oglesby, Walter R.	Schratz, Bruce E.	Tabor, Marcella A.	Wilson, James W.
Osam, Patrick N.	Schroeder, George T.	Tamas, David E.	Wilson, John L.
Osteen, Paul	Schultz, John C.	Tanner, James A.	Wilson, R. Sloan
Ozment, Kerry	Schwander, L. Howard	Taylor, David R.	Wolverton, John
Padberg, Frank T.	Seruggs, Jan W.	Taylor, Eugene H.	Wong, Ting C.
Paddock, George	Searey, Robert M.	Tedford, John G.	Wooten, Virgil

Workman, W. Wayne
 Wortham, Thomas H.
 Wright, Ruel N.
 Yamauchi, Terry
 Yocum, John
 Young, Douglas E.
 Zelnick, Paul

Randolph County

Baltz, Albert L.
 Baltz, Mark
 Barre, Hal S.
 DeClerk, Thomas
 Holt, Danny B.
 Jansen, Andrew J. III
 Mize, James S.
 Murrey, James F.
 Scott, William W.
 Smith, Norman K.
 Smoot, John D.

Saline County

Ashby, John W.
 Ashby, Robert
 Baber, Quin M.
 Bethel, James
 Burton, Charles R.
 Caldwell, David L.
 Cash, Ralph D.
 Coker, S. Dale
 Cooper, James B.
 Cornwell, Samuel L.
 Council, Robert A. Jr.
 Duncan, J. Shelby
 Eaton, James M.
 Gardner, Dan R.
 Hill, Edward B.
 Hill, Howell V.
 Hogue, F. Paul
 Hood, C. Ted
 Izard, Ralph S. Jr.
 Johnston, Greg
 Kirk, Marvin N. Jr.
 Martindale, J. L.
 Ramsay, Rex C. Jr.
 Smith, Robert
 Stewart, David L.
 Sudderth, Brian F.
 Taggart, Sam D.
 Thibault, Frank G. Jr.
 Thomas, Bill R.
 Thorn, Harvey Bell Jr.
 Tilley, Roger L.
 Vinc, Donald L.
 Wagner, Taylor
 Watson, Kirk D.
 Wright, John D.

Sebastian County

Aeklin, Jimmy D.
 Albers, David G.
 Alberty, Joe
 Anderson, Paul
 Atkins, Jimmie G.
 Axelsen, Nils K.
 Bailey, Charles W.

Baker, Max A.
 Barker, Robert Jr.
 Barnes, L. Ford
 Barr, Marilyn
 Barry, James Jr.
 Beachy, Allen L.
 Berryhill, Richard E.
 Berumen, Mike
 Bordeaux, Ronald A.
 Bradford, A. C.
 Brown, Byron L.
 Brown, James A.
 Brown, Richard
 Buie, James H.
 Builteman, James
 Burks, Deland
 Busby, J. David
 Cain, Martin
 Carson, Randall L.
 Carter, D. Mike
 Cassidy, Calvin R.
 Chambers, Donald
 Chamblin, Don W. #
 Cheshier, James L.
 Chester, Robert L.
 Cheyne, Thomas
 Coffman, Edwin L.
 Coleman, Michael D.
 Crow, Neil E. Sr.
 Crow, Neil E. Jr.
 Culp, William C.
 Daily, Richard
 Davenport, O. Leo
 Deaton, John M.
 Deneke, James S.
 Desrochers, Paul E.
 Dorzab, Joe H.
 Drolshagen, Leo F. III
 Dudding, William F.
 Edwards, Gary
 Ellis, Homer G.
 Ennen, Randy
 Everett, Karen
 Faier, Samuel
 Feder, Frederick P. Jr.
 Feezell, Randall E.
 Feild, T. A. III
 Felker, Gary V.
 Ferrell, Jeffrey
 Fisher, Robert D.
 Floyd, Charles H.
 Francis, Darryl R. II
 Franz, Floyd
 Gamble, Cory
 Gedosh, Edgar A.
 Gill, James A.
 Girkin, R. Gene
 Glover, D. Bruce
 Goodman, R. Cole Jr.
 Goodman, Raymond C. Sr.
 Graves, Stephen C.
 Griggs, William L. III
 Gwartney, Michael P.
 Hanley, Larry L.
 Harmon, Pamela
 Hathcock, Alfred B.
 Heim, Stephen
 Hendrickson, Jon
 Hendrickson, Kathryn
 Henry, James
 Herren, Adrian L.

Heusinkveld, Robert S.
 Hewett, Archie L.
 Hinkle, Richard A. Jr.
 Hoffman, John D.
 Hoge, Marlin B.
 Holman, William A.
 Holmes, Williams C. Jr.
 Hornberger, Evans Z. Jr.
 Howell, James T.
 Hughes, Robert P. Jr.
 Hunton, David W.
 Hunton, Teresa H.
 Huskison, William T.
 Hyde, Marshall L.
 Ingram, Ralph N.
 Irwin, Peter J.
 Jagers, Robert
 Janes, Robert H. Jr.
 Jefferson, Christina M.
 Jefferson, Thomas C.
 Jones, W. Duane
 Kalee, John M.
 Kareus, John L.
 Kelly, Thomas C.
 Kelsey, J. F.
 Kennedy, Virgil N.
 Kientz, John Jr.
 Klopfenstein, Keith
 Knight, William E.
 Knuble, William A.
 Koehler, David B.
 Koenig, A. Samuel III
 Koenig, Albert S. Jr.
 Kradel, R. Paul
 Kramer, Ralph G.
 Kutait, Kemal E.
 Lambiotte, Louis O.
 Landherr, Edwin
 Landrum, Annette V.
 Landrum, Samuel E.
 Lane, Charles S. Jr.
 Lange, John L.
 Lenington, Jerry O.
 Lewing, Hugh S.
 Lilly, Ken E.
 Lockhart, William G.
 Lockwood, Frank M.
 Long, James W.
 MacDade, Albert D.
 Magness, Jack L. Jr.
 Manus, Stephen C.
 Martimbeau, Claude
 Martin, Art B.
 Martin, Rick
 Marvin, Michael
 Masri, Hassan M.
 McClain, Merle
 McClanahan, J. David
 McCraw, Gordon
 McDonald, H. P.
 McEwen, Stanley R.
 McKinney, Robert
 McMinimy, Donald
 Meador, Don M.
 Miller, Robert C.
 Mings, Harold H.
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Contraindications: VASOTEC® (Enalapril Maleate, MSO) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, Drug Interactions and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (>5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See Drug Interactions.)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methylglucoside, nitrates, calcium-channel agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy—Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radiocactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters. There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not

been clearly defined, VASOTEC® (Enalapril Maleate, MSO) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypotension, or the underlying prematurity.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of ¹⁴C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, Hypotension); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances; atrial fibrillation; palpitation.

Digestive: Ileus, pancreatitis, hepatitis (hepatocellular or cholestatic jaundice), melena, anorexia, dyspepsia, constipation, glossitis, stomatitis, dry mouth.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION). *Respiratory:* Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, hyperhidrosis.

Special Senses: Blurred vision, taste alteration, anosmia, tinnitus, conjunctivitis, dry eyes, tearing.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgias, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings:

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol%, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension:* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance > 30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤ 30 mL/min (serum creatinine ≥ 3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, Drug Interactions.) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, Pharmacodynamics and Clinical Effects.) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Patients with Heart Failure and Renal Impairment or Hypotension: In patients with heart failure who have hyponatremia (serum sodium < 130 mEq/L) or with serum creatinine > 1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, Heart Failure, WARNINGS, and PRECAUTIONS, Drug Interactions.) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD Representative or see Prescribing Information, Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19386. J9V561R2(820)

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Introduction

Charles Rodgers, M.D.

Chairman, Governmental Affairs Council

January 14, 1991, marks the beginning of the 78th Session of the Arkansas General Assembly. Each year, more and more medical-related issues are being considered by the Arkansas legislators. . . issues that have a tremendous impact on patient care, clinic administration, and physician reimbursement.

This insert contains a brief synopsis of several key issues that will effect the practice of medicine. Through discussions with legislators and other health-related groups, we have identified a list of probable legislative proposals.

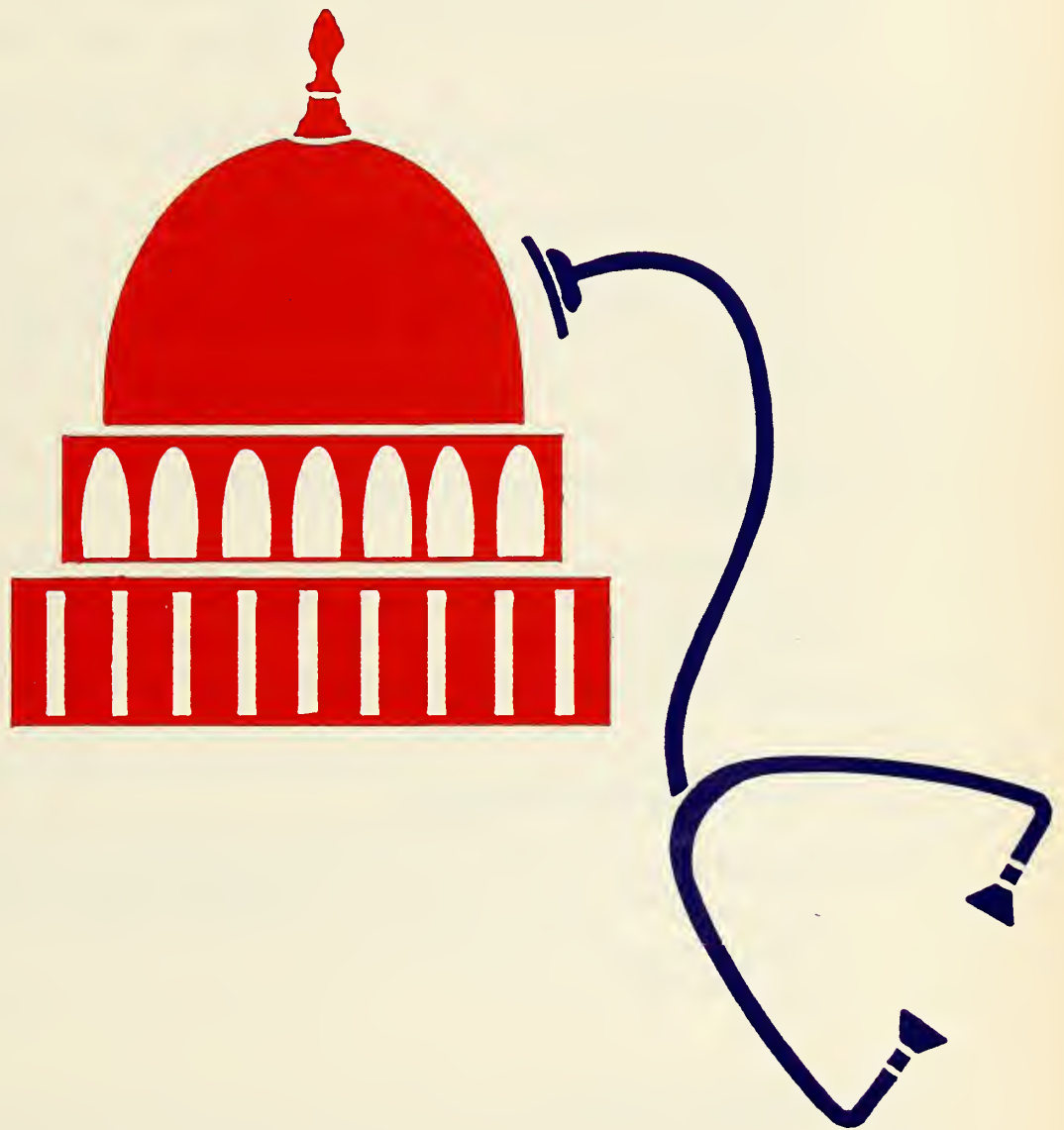
Also, the AMS Governmental Affairs Council has taken a proactive role in developing legislative proposals designed for the benefit or protection of physicians and their patients. This model legislation is also discussed in this special legislative review.

Because medical issues are often complex, it is imperative that AMS members familiarize themselves with the issues and discuss them with their local legislators. AMS members are also urged to read the weekly legislative updates and respond to requests for legislator contact. Amendments to proposed bills can completely change the intent of legislative issues, and it is important for physicians to keep up-to-date on the progress of individual pieces of legislation.

The members of the AMS Governmental Affairs Council have devoted many hours in both identifying issues damaging to the profession and preparing model legislation that will better serve the profession. All these efforts will be futile unless individual physicians, statewide, respond to the legislative process when needed.

To obtain specific details on legislative proposals, contact the AMS Department of Governmental Affairs by calling 1-800-542-1058 or 224-8967 in Little Rock.

AMS
GOVERNMENTAL AFFAIRS
COUNCIL



1991 LEGISLATIVE PROPOSALS

AMS SPONSORED

1. Reduction of Statute of Limitations

The AMS will sponsor a bill which will reduce the statute of limitations for the treatment of minors from age 20 down to age 9. This bill was introduced two years ago and passed the House of Representatives. Not unexpectedly, the bill failed in the Senate Judiciary Committee.

2. Civil Immunity for Treatment of Indigent Patients

In the 1989 Legislative Session, the AMS sponsored a bill that granted civil immunity to physicians who treat patients under the AMS indigent health care program. This bill passed the Senate and House, but was vetoed by the Governor. The Governor has since stated that he may reconsider his position.

3. Immunity for Reporting of Impaired Doctors

The AMS Physician's Health Committee assists those physicians who are impaired due to alcoholism or other chemical dependency. The AMS will sponsor legislation granting immunity to those physicians who report their suspected colleagues to this committee in a request for intervention.

4. Tobacco Related Proposals

The AMS will join with a coalition of other providers and interested parties in support of anti-smoking legislation. Proposals will likely include an increase on the cigarette tax, banning smoking in public places, and the removal of cigarette vending machines.

5. Insurance Reform

In the area of insurance reform, the AMS is currently reviewing several proposals in regard to payment by third-party payors. One proposal will require the third-party payors to notify the physician when an insurance

payment has been made to the patient or would require co-signatures, i.e., the signature of the provider and the patient before a third-party payor check or draft could be cashed. Another proposal will require insurance companies to provide a list of the policy exclusions to every insured, not just the master contract holder. The Society is also considering legislation which would limit insurance company access to the illness under review, and not the entire patient chart.

6. Third Party Payor Responsibility

The AMS will again sponsor legislation which provides that third-party payors shall be liable for injury to patients resulting from adverse utilization review decisions.

7. Physician Reporting of Drug Abusers

Physicians are currently prohibited by patient confidentiality rules from reporting patients, particularly walk-ins, that are doctor shopping for the purpose of obtaining drugs. The AMS will pursue legislation that protects physicians in the reporting of suspected cases.

8. AIDS

As further protection against the spreading of the AIDS virus, the AMS will pursue legislation requiring strict testing by agencies that collect blood products for the purpose of resale or distribution. Donors testing positive will be re-tested for confirmation of the HIV infection and their names will be made available to the Arkansas Department of Health for the purpose of contact tracing and partner notification.

9. Regulation of Tanning Facilities

The use of tanning facilities has resulted in increased incidents of skin cancer and adverse medical reactions by persons using certain medications. The AMS will propose legislation which regulates tanning facilities and requires disclosure, both written and posted, warning of the dangers of using certain tanning devices.

AMS SUPPORTED

1. Uninsurable Risk Pool

The Arkansas Medical Society, the Arkansas Hospital Association, and a coalition of health insurance carriers have developed legislation establishing an uninsurable risk pool. This pool will provide insurance coverage for those persons who have been denied insurance coverage due to pre-existing conditions or other disqualifying factors. Persons eligible for the risk pool will purchase coverage at a cost of approximately 150% of the highest standard market price. Additional funding will be accomplished through either a cigarette tax or an income tax surcharge.

2. Safety Issues

The AMS will again be involved in a safety coalition that will support a mandatory seat belt law and oppose a repeal of the current Arkansas Motorcycle Helmet Law.

3. Open Drug Formulary

In support of the theory that physicians should maintain the right to treat a patient as they see fit, the AMS would be supportive of an open Medicaid Drug Formulary Law if proposed by the Pharmaceutical Manufacturers.

4. Increase OBG Participation

The AMS will join with the Arkansas Department of Health in supporting legislation that will help increase the number of physicians treating pregnant mothers and delivering babies. We will support civil immunity laws for the treatment of obstetrical cases and/or any efforts by the state to reimburse physicians for their malpractice insurance premiums.

5. Life Support

With an increased awareness of "Living Wills" and withdrawal of life support

systems, the AMS will work in conjunction with the Arkansas Bar Association to review the current statutes.

6. Prohibition of Bottle Rockets

The AMS supports the ophthalmologists who will introduce legislation banning the sale of bottle rockets in an effort to reduce the number of injuries to the eye.

7. Public Health Risk

The Department of Health will consider legislation further regulating the practices of tattooing, ear-piercing and aspects of cosmetology. The AMS shares their concern for possible risk of blood borne disease.

8. Rural Medical Practice Incentives

The AMS will support legislative efforts to increase the incentives for rural medical practices through loan forgiveness programs, tax incentives, and more dollars for student loan programs.

AMS OPPOSED

1. Adverse Legal Reform

The AMS will continue to oppose efforts by the trial lawyers to establish pre-judgement interest for lawsuits that have yet to be litigated and any change that they may propose under the Arkansas Comparative Fault Law.

2. Mandatory Assignment

Although a mandatory assignment for Medicare reimbursement bill has not been proposed in the last four years, there seems to be a renewed interest on the part of senior citizens in support of such legislation. The AMS will continue to oppose mandatory assignment of Medicare fees in order to maintain licensure.

3. Expanded Practice by Limited Licensed Practitioners

The AMS will continue to oppose any increase in the scope of practices of physical therapists, medical technologists, social workers, and nurse practitioners. The medical technologists are exploring legislation which would require a certified medical technologist in every physician's office. Such legislation would remove the physician's authority to appoint office personnel to fulfill these key positions and would place a burden on rural physicians due to the shortage of certified medical technologists in our state. The AMS will continue to oppose efforts by physical therapists to treat patients without physician referral. The AMS will continue to oppose direct insurance reimbursement to social workers at a rate comparable to psychiatrists. The AMS will oppose efforts by nurse practitioners to expand their scope of activity to include prescribing drugs.

4. Insurance Policy Limitations

The AMS will review legislation which would allow insurance companies to provide bare bone policies for insured groups of fifty persons or less. These "bare bone policies" would exclude such mandatory benefits as treatment for mental or emotional disorders, well baby care, mammography screening, and other normally accepted insurance benefits.

5. Triplicate Prescriptions

The AMS will oppose any efforts to establish a triplicate prescription program for Schedule II Drugs. We feel that this is government overkill and would penalize the 99% of the physicians who are trying to practice good medicine in an effort to punish the 1% of the abusers. A triplicate prescription program would only cause additional cost and an administrative problem for Arkansas physicians.

6. Assignment of Benefits

A recent Arkansas court ruling nullified the requirement by some insurance companies that providers accept certain conditions in order to receive direct payment from the companies. The ruling restores the patient's right to assign benefits directly to the providers if they so choose. If this ruling is upheld, the

AMS will oppose legislation designed to take away the patient's right to assign benefits directly to the provider.

AMS NEUTRAL

1. School-Based Health Clinics

The State Legislature will again debate the issue of school-based health clinics, with particular emphasis on the issue of pregnancy counseling.

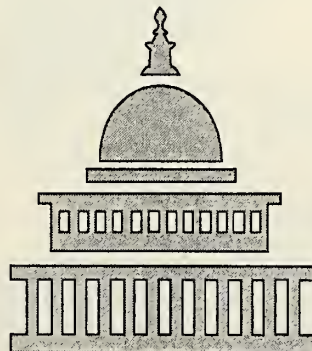
2. Increased Emphasis on Primary Care by UAMS

Legislation is being considered which would reduce the funding to the medical school if a certain percentage of future students produced are not primary care physicians, with a percentage of those being family physicians.

REGULATORY ACTION

1. Workers Compensation

There is an increased emphasis by the business community to establish a fee schedule for the treatment of workers' compensation patients. The AMS is currently working with the Arkansas Workers' Compensation Commission in developing a schedule. A fee schedule offered by the Workers' Compensation Commission and instituted by regulation would be preferable to a schedule that was passed by statute because a legislative/statutory fee schedule could only be changed every two years by action of the Arkansas General Assembly.



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The Placebo Effect and Affect

Lee Abel, M.D.*

As defined in the dictionary, a placebo is "an inactive substance or preparation given to satisfy the patient's symbolic need for drug therapy, and used in controlled studies to determine the efficacy of medicinal substances."¹ Physicians know that placebos are not simply inactive substances that reliably have no effect. They can be remarkably active and cause real symptoms. No control group has yet been found that reported absolutely no side effects from the placebo medications. Just as placebos can cause real symptoms, they may also relieve real symptoms. A patient whose pain is relieved by a placebo has experienced as true relief from pain as that patient given morphine. The discovery of endorphins has given an inkling into the mechanism of some placebo responses. However, the placebo effect remains a poorly understood part of normal human behavior. It is neither intrinsically good nor bad, but represents a mysterious and challenging part of clinical medicine.

Two recent articles from the *New England Journal of Medicine* illustrate some of these challenges. One study by Jewett et al concerns symptom provocation testing, which is a controversial but apparently widespread practice used by clinical ecologists to detect alleged food allergies.² Physicians who practice clinical ecology claim food allergies are responsible for a large variety of nonspecific symptoms (headache, nausea, bloating, fatigue, insomnia, tinnitus, palpitations, breathlessness, ankle swelling, etc.) In provocation testing, patients are given subcutaneous or intramuscular injections of food extracts. If symptoms are provoked, patients are then given other doses of the extract until a dose is found which neutralizes the first dose and relieves the symptoms. The article is a very well done, double-blind study carried out in the offices of "seven experienced clinical ecologists in private practice who were proponents of symptom provocation testing." These private practitioners hand picked the study patients on the basis of the patients' previously demonstrated reliable responses to provocation test-

ing. The results were surely surprising to the participants, for it showed there was no difference between placebo and active allergen in either provoking or relieving symptoms. The authors conclude "the technique as practiced works only if practiced unblinded - that is, under the influence of direct or indirect suggestion."

Seeing is believing, and it is often difficult for physicians to be detached, objective observers. We want to make patients better and are gratified when improvement follows our treatment. This temporal relationship easily becomes a causal one in our minds. Thus, it is understandable that physicians who have "seen" provocation testing help polysymptomatic patients express reluctance to stop doing a technique that seems benign and helpful (at least in the short run). Likewise, it can be anticipated that patients who have been given a scientific explanation for their woes may not be happy with the idea that their improvement was a placebo effect. The clinical ecologists who participated in this study should be applauded for submitting their beliefs to scientific scrutiny, but most physicians will view the study results as discrediting provocation testing and conclude that such testing should cease.

Being misled by a placebo effect is not just an experience confined to practitioners on the fringes of mainstream medicine. Many formerly standard but now abandoned procedures and treatments attest to this fact. A good example of a current modality accepted by mainstream medicine which may be no better than placebo is transcutaneous electrical nerve stimulation (TENS). Deyo et al studied TENS alone and combined with an exercise program in the treatment of chronic low back pain.³ They found TENS was no better than placebo and added nothing to exercise alone. TENS may have gained more acceptance than provocation testing because it has an attractive scientific rationale (gate control theory of pain transmission). Even if future studies confirm the work of Deyo et al, these negative results may be difficult for practitioners of TENS to accept because they have been so strongly affected by the placebo responses of their patients. Indeed, in the subsequent letters to the editor, this article was criticized by proponents of TENS who felt

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TENS was efficacious with the negative results of Deyo et al being due to improper TENS technique.⁴ The critics, however, each had differing views as to what was the proper TENS technique.

It is sobering to realize there will never be enough randomized, double-blind, placebo controlled scientific studies to settle all clinical issues. Physicians will always be left with large areas of practice that are more art than science. Articles such as these remind us of the powerful nature of the placebo effect, both on the patient and on the physician, and challenge us to retain objectivity and humility about our own cherished treatment modalities.

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Congestive Heart Failure

Mechanism & Medical Management

J. Douglas Holloway, M.D.*

Introduction

Congestive heart failure (CHF) is a health problem of major proportion. The National Heart, Lung, and Blood Institute estimates that over 2,000,000 Americans are afflicted with CHF, with 400,000 new diagnoses each year. The remarkably poor prognosis attendant to this diagnosis (up to 60% one year mortality in those severely affected) further underscores the public magnitude of the CHF syndrome.

This paper will review the pathophysiology and proper therapy of CHF. Comments will be largely restricted to chronic medical management of the patient with CHF due to left ventricular systolic dysfunction (congestive cardiomyopathy).

Definition and Etiology

A standard definition of CHF is "the inability of the heart to deliver adequate blood to peripheral tissues to meet their metabolic demands." Such circulatory insufficiency classically results from diminished myocardial contractile capacity owing to a number of causes, including prior infarction, longstanding hypertension, pressure or volume overload from valvular or congenital disorders, infectious agents, and toxins. Certain patients demonstrate diminished forward cardiac output despite normal left ventricular systolic function. These clinical subsets are important to distinguish, and include ventricular diastolic dysfunction (usually in association with muscular hypertrophy), and certain aortic and mitral valve diseases.

Pathogenesis

Diminished pumping capacity of the heart leads to

fatigue and weakness ("forward failure"). Moreover, as the ventricle is unable to expel its contents, "backward failure" results, with dyspnea and orthopnea created by pulmonary venous hypertension.

Blunted cardiac output from whatever etiology activates a complex array of neuroendocrine systems. These adaptive mechanisms were perhaps teleologically designed to protect man from heart failure resulting from blood loss rather than dysfunctional myocardial processes. The resultant vasoconstriction and fluid retention serve a more maladaptive role in the modern age, creating a vicious cycle of progressively poor forward flow and heightened neuroendocrine response.

Renin released from the poorly perfused kidney (and other vascular beds) produces angiotensin-related vasoconstriction as well as aldosterone-mediated sodium and water retention. Plasma norepinephrine levels are elevated, a fact which may have independent prognostic significance.¹ Moreover, pituitary release of vasopressin causes vasoconstriction and an antidiuretic effect.

The adverse volume expanding and vasoconstrictor mechanisms are partially counteracted by endogenous atrial natriuretic factor (ANF) and vasoactive prostaglandins. ANF is a family of peptides released by stretched cardiac atria, promoting natriuresis and diuresis. Prostaglandins E₂ and I₂ cause vasodilation, helping to maintain hemodynamic homeostasis.

Modern management of CHF is aimed at intervening in the pathophysiologic cycle at several points - provoking diuresis, augmenting myocardial contractility, and "unloading" the ventricle with venodilation and afterload reduction.

Medical Therapy

Traditional treatment of CHF was, until recently, limited to digitalis and diuretics. Vasodilating drugs have gained widespread acceptance since the late 1970's, particularly in light of recent data demonstrating a survival advan-

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tage when these agents are employed. Contemporary CHF treatment involves proper selection of drug combinations, tailoring therapy for a patient's individual needs.

Digitalis

By inhibiting sodium and potassium ATPase, digitalis indirectly increases intracellular calcium. This augments the contractile force of the failing heart (positive inotropic effect). Apart from its inotropic effect, digitalis exerts salutary effects in slowing the ventricular response to atrial fibrillation, which often accompanies CHF.

Support for the use of digitalis in CHF is modest. Conflicting results have been noted in prospective randomized trials of digitalis therapy. Lee reported improved ventricular performance, functional class, and exercise duration in those patients with cardiomegaly and an S3 gallop.² Contrariwise, in a somewhat different population of patients with stable chronic CHF, Fleg demonstrated no benefit from digitalis therapy.³

These mixed study results indicate that routine use of digitalis is not warranted in all CHF patients. In those with mild symptoms and reasonably preserved left ventricular systolic function, digitalis is unlikely to provide any sustained benefit. The severely symptomatic patient subgroup can derive the most benefit from digitalis. However, because of perturbations of renal function, this subgroup is also at risk of digitalis toxicity. Therefore, digitalis is most properly used in the patient with moderate to severe symptoms, and those with atrial dysrhythmias. Careful monitoring of clinical parameters and serum digitalis levels is advised.

Diuretics

Diuretic drugs are a mainstay of therapy for many CHF patients. By retarding renal tubular sodium reabsorption, both natriuresis and water excretion result. This diuretic effect provides relief from peripheral and pulmonary interstitial and alveolar edema. Furosemide and bumetanide are potent loop-active diuretics which rapidly reduce circulating volume ("preload" reduction). Metolazone and thiazide diuretics are somewhat less potent but frequently effective, either alone, or in combination with loop diuretics. Thiazide diuretics are ineffective when the glomerular filtration rate is reduced below 30 ml/min. Spironolactone, triamterene, and amiloride are potassium-sparing agents, each with a weak diuretic effect. Special care must be provided to avoid hyperkalemia in the patient treated with both potassium-sparing diuretic and angiotensin-converting enzyme inhibitor.

Diuretics are occasionally appropriate monotherapy for the CHF patient, but generally are best used in an adjunctive manner with digitalis, nitrates, and arterial vasodilators. A significant subset of patients suffer from "forward failure" without prominent pulmonary or peripheral fluid accumulation. Injudicious use of diuretics in these patients can promote prerenal azotemia and metabolic alkalosis.

Despite their important role in providing relief from

congestive symptoms, there is currently no strong evidence that diuretics affect mortality or alter the natural disease evolution of CHF.

Nitrates

Nitrates cause vasodilation via direct relaxation of smooth muscle. This vasodilating effect is particularly prominent in the venous capacitance system, resulting in lowered left ventricular filling pressure and reduced myocardial oxygen consumption. Delivered orally, buccally, sublingually, or transdermally, the optimal dose of nitrates is widely variable. Generally speaking, higher nitrate doses are required to achieve beneficial effect for CHF patients compared to those patients being treated for angina pectoris. With prolonged use of nitrates, tolerance can develop, significantly blunting their hemodynamic effect. Tolerance can generally be avoided by employing a daily 8-10 hour nitrate-free interval. As such, transdermal patch preparations designed for 24 hour use are considerably less popular than when first marketed.

Controlled clinical trials have demonstrated sustained improvement of exercise capacity in CHF patients. However, recent data indicate that a large percent of CHF patients have no significant beneficial hemodynamic response to nitrates, even at substantial doses.⁴ Thus, nitrates are probably most useful when combined with other vasodilating agents.

Hydralazine

By directly relaxing vascular smooth muscle, hydralazine serves as an arterial vasodilator, lowering systemic vascular resistance and impedance to left ventricular ejection. Studies using hydralazine as vasodilator therapy in CHF have shown modest and somewhat inconsistent hemodynamic benefit.⁵ Reflex tachycardia, fluid retention, and lupus-like reactions have somewhat limited more widespread use of this agent in CHF.

The Veterans Administration Cooperative Study on Vasodilator Therapy of Heart Failure (V-HeFT) was a landmark investigation, providing support for the use of vasodilators in CHF.⁶ Hydralazine in combination with isosorbide dinitrate (representing afterload and preload reduction, respectively) was compared with both prazosin and placebo in over 600 symptomatic male CHF patients already being treated with digitalis and diuretics. The two year cumulative mortality rates was significantly better in the hydralazine-isosorbide group (26% vs 34% for the placebo group). Those patients randomized to prazosin fared no better than those treated with placebo. Designed to compare the hydralazine-isosorbide combination with an angiotensin-converting enzyme inhibitor, Phase II of V-HeFT is currently underway.

Angiotensin-Converting Enzyme Inhibitors

Captopril and enalapril (following its hepatic conversion to enalaprilic acid) are specific inhibitors of angiotensin-converting enzyme (ACE). By blocking the vasoconstrictive effects of angiotensin and the sodium and water

retentive properties of aldosterone, these agents serve as potent afterload reducers. Clinically, this translates into decreased systemic vascular resistance and lowered pulmonary capillary wedge pressure. Both of these drugs have been extensively evaluated in the CHF patient. Fairly consistent symptomatic improvement, increased exercise tolerance and hemodynamic benefit have been demonstrated. Adverse effects of the ACE inhibitors include taste disturbance, hyperkalemia, chronic cough, skin rash, and neutropenia. Care must be exercised in patients with renal insufficiency and those with hyponatremia.

A multicenter Scandinavian placebo-controlled double blind study evaluated the effect of enalapril on survival in patients with severe CHF. The investigation was prematurely terminated because of a striking survival benefit in the enalapril treated group (crude mortality reduced 40% at 6 months, and 31% at one year).⁷

Prazosin

Prazosin is an alpha-adrenergic receptor antagonist which effectively produces both arteriolar and venous vasodilation. Inconsistent hemodynamic and exercise benefits were noted in early studies.⁸ Further, in the V-HeFT trial (patients treated with digitalis and diuretic), the addition of prazosin produced no survival benefit over that of placebo. Thus, there is little support of the use of prazosin in chronic treatment of the CHF patient.

Calcium Blockers

With the release of calcium channel blockers, considerable interest was generated regarding the value of these vasodilating agents in CHF therapy. Diltiazem and nifedipine have demonstrated acute improvement of rest and exercise CHF hemodynamics. However, probably because of their negative inotropic effects and augmentation of neurohormonal activation, neither have proven effective in long-term follow-up.⁹

Antiarrhythmic and Anticoagulant Therapy

In reported series of CHF patients, ventricular arrhythmias, rather than inexorable CHF accounts for the majority of deaths. Review of the available pharmacologic and nonpharmacologic arrhythmia treatment modalities is beyond the scope of this article, but this subject has been well outlined elsewhere.¹⁰

Significant morbidity and mortality owing to thromboembolism is seen in CHF patients, particularly in those with concomitant atrial fibrillation. In the absence of exclusionary risk factors, long-term low-dose anticoagulation should be considered in many of these individuals.

Precautions

Certain subgroups of CHF patients deserve special mention, as therapeutic caution is necessary. Individuals with hyponatremia and those with diuretic-induced intravascular vol-

ume depletion are at significant risk of marked hypotension with initiation of ACE inhibitor therapy. Therefore, treatment should be started at low-dose, with careful attention to clinical parameters and laboratory data.

Similarly, patients with severe valvular stenoses (particularly aortic stenosis) cannot substantially increase cardiac output in response to pharmacologic vasodilation, and thus are at risk of profound hypotension with afterload reduction therapy. Such valvular disorders should be ruled out in evaluation of all CHF patients.

Two CHF patient subgroups are unlikely to benefit from vasodilator therapy. Increasingly recognized as a cause of CHF is a disorder of left ventricular diastolic relaxation, in the face of normal systolic contractility. These patients are often hypertensive with resultant left ventricular hypertrophy. Such individuals have no need for afterload reduction; indeed, many respond favorably to drugs which have a negative inotropic effect. Further, those patients with high-output CHF (Paget's disease, hyperthyroidism, arterio-venous fistulae), already have a diminished systemic vascular resistance, and thus pharmacologic afterload reduction serves little purpose.

Future Directions

A group of new nonglycoside drugs create peripheral vasodilation and increase myocardial contractility via inhibition of phosphodiesterase. An intravenous member of this pharmacologic class, amrinone, augments cardiac output and lowers left ventricular filling pressures without significantly increasing myocardial oxygen consumption. Oral phosphodiesterase inhibitors (milrinone, enoximone, and others) have not been overwhelmingly advantageous in early studies.

Through seemingly paradoxical because of their negative inotropic effects, beta-adrenergic blocking agents have some future role in treatment of selected CHF patients. Elevated catecholamine levels in CHF help maintain forward output, but at the expense of increased systemic vascular resistance, activation of the renin-angiotensin-aldosterone system, and possibly a directly toxic effect on the myocardium. Several small studies have demonstrated short-term symptomatic benefits with the use of beta blockers to blunt those deleterious physiologic effects. However, not enough is known to apply beta blocker therapy in the routine clinical CHF situation.

Conclusion

In summary, once a diagnosis of CHF due to left ventricular systolic dysfunction established, proper therapy can achieve much in relieving symptoms of pulmonary congestion and fatigue. Digitalis and diuretics remain appropriate therapy for many properly selected individuals. Contemporary CHF therapy also should include the consideration of arterial or mixed vasodilators, as these drugs have been shown to have a substantial favorable effect on survival. Despite great advances in understanding the complex pa-

thophysiology and therapy of CHF, this group of disorders will undoubtedly remain a challenge for the clinician for many years to come.

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January 1 - December 31, 1990

Total number of cases reported	196	CASES BY AGE GROUP	
Number of deaths	14	Less than 20	10
		20 - 29	54
		30 - 39	73
		40 - 49	30
		50 or more	8
CASES BY SEX			
Male	156		
Female	19		
CASES BY RACE		OPPORTUNISTIC DISEASE	
White	128	Pneumocystic Carinii	75
Black	45	Cryptococcosis	6
Other	2	Kaposi's Sarcoma	1
		Candida	28
		HIV Wasting Syndrome	30
		Toxoplasmosis	5
		HIV Encephalopathy	8
		Histoplasmosis	12
		Other Diseases	10
CASES BY RISK GROUP			
Homosexual/Bisexual	108		
Homosexual & IV Drug User	16		
IV Drug User	17		
Hemophiliac	4		
Transfusion	7		
Heterosexual (Contacts)	10		
NIR#	13		

No identified risk group (NIR)

AIDS IN ARKANSAS 1985 - 1990

Total number of cases reported	428	CASES BY AGE GROUP	
Number of deaths	258	Less than 20	13
		20 - 29	136
		30 - 39	189
		40 - 49	62
		50 or more	28
CASES BY SEX			
Male	388		
Female	40		
CASES BY RACE		OPPORTUNISTIC DISEASE	
White	321	Pneumocystic Carinii	196
Black	102	Cryptococcosis	21
Other	5	Kaposi's Sarcoma	12
		Candida	56
		HIV Wasting Syndrome	47
		Toxoplasmosis	8
		HIV Encephalopathy	24
		Histoplasmosis	28
		Other Diseases	36
CASES BY RISK GROUP			
Homosexual/Bisexual	272		
Homosexual & IV Drug User	44		
IV Drug User	44		
Hemophiliac	6		
Transfusion	18		
Heterosexual (Contacts)	23		
NIR#	20		

No identified risk group (NIR)

Source: Arkansas Department of Health.

AIDS Related Lymphoma

In 1990, we have changed the natural history of HIV infection. Early intervention with Zidovudine, Inhaled Pentamidine (and other PCP prophylaxis), and excellent supportive care have greatly lengthened the life and period of immunosuppression of these patients. It is in this milieu of immunosuppression that AIDS related lymphoma occurs.

CNS lymphomas have been a part of the AIDS case definition since this was first formulated in 1981, but it was several years before other high and intermediate grade lymphomas were noted to be part of the HIV spectrum of disease. In 1984, Ziegler et al reported 90 patients and concluded that the development of lymphoma was a late event. In June 1985, the CDC revised the case definition of AIDS to include high grade B cell lymphomas in the setting of HIV infection. Unlike Kaposi's sarcoma, which occurs almost exclusively in gay men, these lymphomas are distributed evenly among all patients with HIV infection. Registry data confirms the explosive increase. In 1981, 5.7% of lymphomas in never-married men were high grade; by 1985 this had risen to 53.6%. In addition, NHL is the AIDS defining event in 3% of new AIDS presentation.

High grade lymphomas have been known to be associated with conditions that produce profound immunosuppression. They are often heralded by prolonged progressive generalized lymphadenopathy (PGL) and serologic evidence of Epstein-Barr virus (EBV) infection is common, especially in the renal transplant population. DNA probes demonstrate EBV fragments in the B cell DNA in well over one third of patients with these lymphomas, regardless of the cause of immunosuppression.

EBV infection in the setting of AIDS has been demonstrated to produce polyclonal B cell stimulation and it is postulated that aggressive B cell lymphomas arise from one or more of these clones. Twenty percent of hyperplastic nodes have at least one clone of cells with c-myc oncogene rearrangement and in full blown lymphomas, nearly all have c-myc as well as other promoters. (8:14, 8:22 translocation).

The diagnosis of lymphoma in AIDS patients is usually not difficult. Although many patients have PGL, not all progress to lymphoma. Patients with asymmetrical, rapidly enlarging lymphadenopathy should be biopsied, as well as

those with "B" symptoms. A high index of suspicion is crucial. Patients with fever and no obvious source of infection warrant CT examination of chest and abdomen. Extra nodal presentations and advanced disease at presentation are common. All but two patients in Ziegler's original series had extra-nodal disease. Suspicious symptomatology includes ano-rectal complaints (ano-rectal lymphoma may masquerade as a fissure), abnormal LFT's (peri-portal or intra-hepatic presentations are not uncommon), shortness of breath (pulmonary, pericardial and myocardial lymphomas have all been described), and bone pain despite normal plain films and radionuclide bone scan (MRI the imaging modality of choice to demonstrate intramedullary lymphoma). Subtle cognitive changes such as memory loss, confusion, lethargy, in addition to seizures, cranial nerve palsies and aphasia may herald CNS involvement. Lymphoma is confined to the CNS in 25% of reported cases. MRI is the imaging modality of choice for the CNS in AIDS and although multiple lesions are more likely to be toxoplasmosis than single ones, there are no absolutes. In the face of isolated CNS disease, it is reasonable to obtain toxoplasma gondii titers, and if elevated, institute therapy for 10 to 14 days. If the titers are negative, or if the patient deteriorates clinically despite treatment, open biopsy should be considered, depending on patient's overall condition.

Treatment of HIV associated lymphomas is difficult for several reasons. The majority of patients have Stage IV disease at diagnosis, with frequent extra nodal involvement such as bone marrow, CNS or GI tract. In addition, concurrent opportunistic infections (OI) and HIV or ZVD related leukopenia and thrombocytopenia make administration of meaningful doses of chemotherapy difficult. Nonetheless, it is reasonable to attempt treatment in most patients. Although 53% of patients will enter a complete remission (CR) with a variety of standard regimens, this percentage is much lower than for non-HIV related lymphomas and 54% relapse within one year. Median survival is 4.5 months, with one half of the patients dying of recurrent lymphoma and one half dying of OI's. Although extremely aggressive chemotherapy is the rule in young patients with non-HIV related high grade lymphomas, in the setting of HIV it seems to affect survival

adversely. In one study, the median survival of patients treated with greater than one gram per square meter of Cyclophosphamide was 4.6 months. This rose to 12.2 months if they had received less than one gram per square meter. As expected, predictors of longer survival were good Karnovsky status, high T₄ helper counts, low tumor bulk (Stage I or II), no ARC or AIDS symptomatology and no extra-nodal disease. Patients with HIV associated lymphoma should be treated with abbreviated doses of chemotherapy, receive a lumbar puncture as part of the staging workup (17% asymptomatic CNS involvement), and receive four to six cycles of therapy followed by ZVD. Radiation therapy is given to sites of bulky disease.

The decision to treat patients with this disease manifestation is difficult and complicated and it is acceptable to withhold chemotherapy in patients who have low T₄ counts or who have developed NHL after a long, painful, complicated course. These patients are unlikely to derive benefit from treatment and may be harmed by intervention.

One study estimates that up to 40% of patients surviving four or more years after an AIDS diagnosis will develop lymphoma. The face of AIDS is changing and we must adapt to that change. A longer life for someone with AIDS is a double edged sword and physicians must maintain a high index of suspicion for aggressive B cell lymphomas in this population.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage, although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

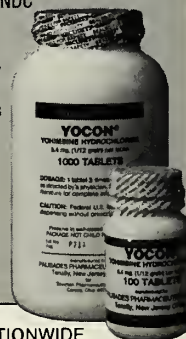
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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1. A. Morales et al., *New England Journal of Medicine*: 1221. November 12, 1981.
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Basil Smith Cantrell, M.D.*

James Smith, M.D.**

Basil Smith Cantrell, M.D. was born on July 29, 1854 in Georgia. He was the son of James H. and Adaline M. Cantrell.¹ His family settled in Wooster, Arkansas after the Civil War where they acquired 160 acres and started farming.² In 1878, he married Nancy L. Hiatt and they had six children.³

In his mid-thirties, Dr. Cantrell decided to change careers. This occurred while the family was still prosperous in farming. However, a variety of unfortunate circumstances could reduce a prosperous farmer to poverty. A farmer's life was hard and uncertain at that time. Cotton was the crop, but excessive rain, poor soil, and low prices could paint a bleak picture at times.⁴ In addition, Dr. Cantrell's father was 65, a widower and not in good health. His brother, John was crippled in one leg from osteomyelitis and of limited use with the farm. The family had been farming their land for 20 years, and some decrease in soil quality could be expected.² He was probably thinking of his difficulties with farming when he wrote to his father during the middle of his medical studies that "I am not going to farm anymore if I can help it."⁵

* Dr. Cantrell never received his medical degree but was regarded as a physician by the communities in which he served many years

** Dr. Smith is an intern with the Department of Medicine at the University of Arkansas for Medical Sciences in Little Rock.

Another influence for Dr. Cantrell to become a physician was the desperate need for doctors in rural Arkansas. Few educated doctors were found outside the larger towns, and it was often impossible to secure help or consultation.⁶



Picture of Dr. Cantrell and his classmates at a dissection table. Dr. Cantrell is the second student from the left. This picture was taken in late 1891 or early 1892.

In 1891, Dr. Cantrell made the decision to study medicine. He left his wife, three sons and new infant daughter in Wooster and took a room in Little Rock as a place live. He was one of 78 first year students, and at age 36, one of the oldest. Dr. John Patton, also from Wooster, had returned to the University of Arkansas Medical Department to further his training and served as Dr. Cantrell's preceptor.⁷

Dr. Cantrell was exposed early in his training to clinical medicine. He mentioned "some very nice surgery and some rather foul work completed" in November 1891, days after he started his studies.⁸ In January 1892, he again wrote of his surgical experiences: "We are having some very interesting cases of surgery. They have treated almost everything you could think of with all sorts of results."⁵ Dr. Cantrell thought highly of his instructors, describing them as "all very smart." He also mentioned his fellow students describing them as "all very green." He informed his brother that "I am up with the rest of my class, which is as sorry as you would like to hear."⁸

Some of his training took him to Benton where he may have served as an apprentice. He stated that he must have looked like a doctor since people called him Dr. Cantrell.²

After one year of medical school, Dr. Cantrell left the program without his M.D. degree. He returned home to his wife and children in Wooster. His family had been through a difficult winter. There had been difficulty in obtaining enough food and wood while Dr. Cantrell had been in school.⁵ Dr. Cantrell started practicing medicine in Wooster and, in a few months, moved to Damascus to practice.²

At the time Dr. Cantrell started his medical practice, anyone who believed himself qualified to practice medicine could be examined by a three member board appointed by the county judge. None of these members had to be physicians. A license to practice medicine could then be granted after this examination.⁹

Dr. Cantrell soon developed a thriving practice in Damascus. Initially in Wooster and Damascus, he had visited patients on horseback. Later he acquired a carriage to visit his patients.² Dr. J.S. Westerfield who practiced in Faulkner County during the same time stated "there was at all times a great deal of sickness and the mortality was high."⁶ Dr. Cantrell's practice grew so large that he fixed boundaries that he would not go past to see patients. Some of his visits were as far as two miles north of Bee Branch, a distance of nine miles from Damascus.¹⁰

Dr. Cantrell was able to move his family into a two story house. His wife would recall that she always had pretty clothes while Dr. Cantrell practiced medicine. He was able to entertain socially, and his son James recalled the local minister being a regular guest for Sunday dinner.²

Despite the limitations of therapy available, Dr. Cantrell had the advantage of knowing his patients very well. This allowed him to pick up mental status changes and have a feel for the prognosis. When called one night to treat a man diagnosed with bowel inflammation, Dr. Cantrell feared for the man's life since the patient did not recognize Dr. Cantrell. The man had known Dr. Cantrell since childhood, and as the patient recovered and recognized Dr. Cantrell, Cantrell was considerably relieved.¹⁰

While in practice, Dr. Cantrell influenced another man to enter medicine. Years after Dr. Cantrell died, Dr. William Hutto was called to treat the wife of his son John C. Cantrell. As he was leaving, Dr. Hutto refused payment for his services. His reason for refusing was that when Dr. Cantrell was practicing medicine he had taken Dr. Hutto with him to visit patients before Dr. Hutto became a physician. Later, Dr. Cantrell took Dr. Hutto to Little Rock and made arrangements for him to enter medical school.²

Dr. Cantrell was planning to return to school to complete his courses and receive his medical degree. His life was tragically cut short. In September 1894, Dr. Cantrell became seriously ill and took to his bed. A man came to his house asking Dr. Cantrell to treat his three-year-old daughter. Dr. Cantrell initially refused because of the severity of his own illness. The man burst into tears stating that his daughter was going to die if Dr. Cantrell did not treat her. Looking at his own three-year-old daughter, Dr. Cantrell realized he would want his daughter treated if she were sick. Dr. Cantrell

instructed his wife to get his buggy ready and to help him get dressed. The child recovered from her condition, but Dr. Cantrell's condition worsened. Two days later, on September 27, 1894, he died from what one local doctor thought was spinal meningitis.²

Hard times fell upon the family as many patients who owed bills to Dr. Cantrell refused to pay their debts to his widow. She was unable to keep the house Dr. Cantrell bought for the family. Her two oldest sons left home as soon as they had grown up.²

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2. Interview with Mevrouw Cantrell Coburn on March 3, 1990.
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5. Letter of Basil Cantrell to James H. Cantrell, January 24, 1892.
6. Westerfield J. On medicine in Arkansas. Arkansas Gazette, January 16, 1949:1B.
7. Enrollment roster, entering class of 1891, University of Arkansas Medical Department.
8. Letter of Basil Cantrell to John W. Cantrell, November 9, 1891.
9. Baird WD. Medical education in Arkansas 1879-79. Memphis State University Press, Memphis, TN, 1979:51.
10. Letter of Basil Cantrell to John W. Cantrell, January 9, 1894.

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Why They Sue: Motivation Often Not Related to Medical Injury

Robert J. Miller*

Sixty-five-year-old widow: When my husband was in the intensive care unit, following a major heart attack, I tried for over a week to speak with his cardiologist. He never returned any of my phone calls. Suddenly, one morning, I received a phone call from the hospital; my husband was being discharged from the hospital. He was so weak that he could barely walk. He was wearing a catheter, which I had no idea how to care for. There had been no discussion about diet, about the possibility of getting a visiting nurse to bathe my husband or help him to get in and out of bed. I didn't know if we needed to rent a hospital bed. I am not in good health myself. My husband was a large man and there was no way that I could have caught him if he fell. I had many questions about my husband's care. I just didn't think he was in any shape to come home. When I told the hospital that I wanted to talk with my husband's doctor before discharge, they became insistent. I angrily hung up the phone and refused to respond to any calls that day. On the following morning, bright and early, I received a phone call from the cardiologist. I said to him, "Well, now you're finally ready to talk to me!" They insisted my husband come home that day and two days later he died on the bathroom floor as a visiting nurse was trying to help him. I'm really very bitter about the way we were treated.

Married couple, in their late 20s: We had been unsuccessful in having a family, so my gynecologist referred us to a local infertility specialist. Within six months, following some corrective surgery, I was pregnant and happily returned to the care of my OB/GYN—who had been my doctor

for nearly ten years. One evening, when I was four months pregnant, he called me at home and began the conversation by asking me if I was still pregnant. Somewhat startled, I said yes. "Well," he said, "I'm tired of your insurance company and I don't want to mess around with them any more so you're going to have to find another doctor." I was dumbfounded. In the first place, my husband has very good medical insurance and they had never given us any trouble, even when we were going for infertility treatment. Secondly, I'd thought we were friends. Even though he'd been my doctor for so many years, he must have decided that I was a high risk pregnancy and he didn't want to be bothered. It was like having a friend tell you they didn't like you any more.

Forty-year-old college professor: I had been having a lot of trouble with colds and sinus problems. Eventually, my family doctor recommended a local allergist. The examination began with the doctor walking into the room, putting my chart down on a counter and, with his body and head turned sideways to me, said, "What seems to be the problem?" There was no introduction, no smile, no eye contact, no feeling of personal contact at all. He may have been a great doctor, but I never went back to him. I thought "If you have such poor interpersonal skills that you can't even introduce yourself or look at your patient, you're not the doctor for me".

Father of a fifteen-year-old student: My daughter had been placed in intensive care with an unidentified respiratory problem. A local pulmonologist was called in for a consultation. He arrived at 6:00 a.m.; my daughter was asleep and had been given pain medication so she was really out of it. This guy started asking her questions and, of course, she didn't respond. I was in the room and was perfectly capable

* Mr. Miller is Vice President-Consumer Affairs and Risk Management for The Medical Protective Company of Fort Wayne, Indiana.

of answering his questions, but he didn't want to talk to me. He became quite irritated when she couldn't wake up and talk with him. His parting shot, as he left the room was, "The trouble with a lot of these kids is that they don't get enough exercise." If he had bothered to look at my daughter's chart he would have seen that she played three varsity sports, rides horseback and is a member of a U.S. junior Olympic team. I was irate.

Owner of a small print shop: I was referred to an ophthalmologist and, because my company has only four employees, every worker is important. Before I left work for my appointment, I called ahead to see if they were running on time. "Yes," I was told. "We'll be ready for you as soon as you arrive." Following a two-hour wait I was finally ushered into an examination room—where I cooled my heels for another forty-five minutes. I would have left, but I kept thinking that I'd just have to go through the same wait all over again. It's bad business to keep people waiting like that.

Thirty-three-year-old mother of two: When I was pregnant with my first child, I went to one of my regular visits one day and when my doctor walked into the room, he had a strange man with him. "This is Dr. So-and-so," he said, "and he's going to examine you too." Here I was, trussed up like a Thanksgiving turkey and being examined by a total stranger. I really resented the fact that my doctor didn't ask me first. People shouldn't be made to feel like Show-and-Tell presentations. They are people first and their privacy shouldn't be invaded. I'm certain that doctor was a good physician, but when I got pregnant the second time, I switched obstetricians—and that one incident was the reason. It may not be logical, but I couldn't forgive him for that incident.

Retired college professor: This young hotshot anesthesiologist came to visit with me before my surgery. "Well, Pat," he said, "let's talk about your surgery." I said to him,

"Doctor, I am not going to call you by your first name out of respect for your education and because we have an essentially professional relationship. And you are not going to call me by my first name out of respect for my education and because I am thirty years your senior!"

Mother of ten-year-old pediatric patient: We were new in town and had just visited a pediatrician who had been recommended to us. When we got out to the car it became apparent that my son was quite angry. "What's the matter?" I asked. "Dr. Smith talks more to Dusty than that guy talked to me; he treated me like I was too stupid to talk on my own!" my son fumed. (Dr. Smith is our family veterinarian and Dusty is our dog.) We found a different pediatrician.

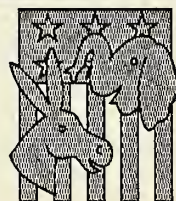
Seventy-two-year-old grandmother: I'm a diabetic and last year I had a pretty bad heart attack. During my recovery, my heart doctor changed my insulin prescription. I tried to convince him that he needed to talk with my family physician first. I've been seeing my family doctor for over thirty years and he really knows me. The heart doctor basically ignored me. He knew it all. Well, two days later I had a serious insulin attack and almost ended up in the hospital. My family doctor was very angry; he said the heart doctor had no business changing my insulin without discussing it with him.

Forty-two-year-old bank vice president: My family has gone to the same internist for years. I really liked him. You could talk to him and he really seemed to care about us. When I became ill he was very supportive, really quarterbacked all the diagnostic consultations, came to see me every day when I was in the hospital. The we got the bad news that my condition was terminal and poof! he was gone. He just faded out of the picture. Maybe he felt that I was better off in the care of the specialists but I felt as though he had just written me off.



Day at the Capitol

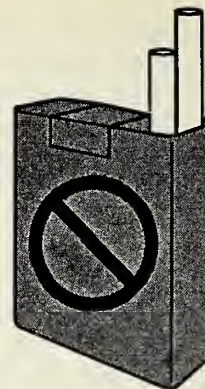
Wednesday, February 6, 1991
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The program begins at 10:00 a.m. with a legislative briefing and a luncheon address by a member of the 78th General Assembly. Following lunch, the attendees will go to the State Capitol to observe the proceedings and visit with their legislators.

Again this year, surprise entertainment will highlight the Society's Legislative Reception honoring the members of the Arkansas legislature. All day attendance would be beneficial, but the AMS Governmental Affairs Council especially encourages physicians and spouses to attend the evening reception. It is imperative to have at least ONE Society member from every legislative district.

Smoking in the Workplace



David S. Bachman, M.D.*

Until recently, the non-smoker's grumblings about smoking in the workplace fell on deaf ears. The majority of workers smoked -- it was the thing to do. That non-smoking grumbler was considered a complaining misfit.

With recent studies revealing the adverse effects of "second-hand smoke," new light has been shed on this problem. We know that smoking is not a mere nuisance to the non-smoker -- it is a definite health hazard.

Resentment toward smoking in the workplace is increasing daily. A recent Harris poll revealed that 80% of our adult population favors legal restrictions as to where one can smoke. Surprisingly, 75% of the smokers were also in favor of legal restrictions.

Non-smokers' rights groups are both multiplying and winning victory after victory in their attempts to clean the air. Smoking is now banned on all domestic airline flights, and restricted on Amtrak trains, and in public buildings, hospitals and doctors offices. The last smoking stronghold seems to be the workplace.

What are the Employer Advantages in Having a Smokefree Workplace?

1. Fewer lost work days per year. The number of workdays lost per year is doubled for smokers.
2. Wage cost savings. A study by Dow Chemical Company reveals that there is an additional wage cost per year per smoker of \$234 due to absenteeism.
3. Smokers perform less work per day than non-smokers. The figure is worse for pipe smokers.
4. Work efficiency has been estimated at 2% to 10% for smokers.
5. In workers paid \$25,000 per year, the smoker was paid

\$1500 of their employer's money while smoking in the workplace.

6. When time lost from smoking is combined with time lost due to absenteeism, the average smoker gives the employer 17 days less of work time per year.

Insurance Rates

A smoke-free workplace, can result in lower insurance rate due to the following:

1. Smokers burden the health care system one and a half times more than non-smokers.
2. Industrial accident rates for smokers are twice that of non-smokers.
3. Death rates for smoking policy holders in all age categories are two and a half times greater than in non-smokers.
4. Careless smoking is the cause of 30% of building fires and accounts for 97.4% of the fatalities in structural fires.
5. At least 35 insurance companies sell health insurance policies at a lower rate to non-smokers.
6. Smokers are killed in fatal auto accidents 2.6 times more often than non-smokers.

The cost of a health insurance package can be considerably lower in a non-smoking workplace.

The Cost of Replacing Experienced Workers

The replacement and training of experienced workers is a costly item for any industry.

Two-pack-a-day smokers are 2.76 times more likely to die between the ages of 45 to 54 than non-smokers.

Only 60% of 22 year-old smokers will live to age 60; whereas 85% of non-smokers can be expected to live that long.

* Dr. Bachman practiced as a general surgeon and brochoesophagologist at the Millard-Henry Clinic in Fort Smith for 20 years. He is now retired and resides in Dardanelle, Arkansas.

Cost of Life Insurance

Insurance companies report a seven times greater payout to smokers due to increased disability and death.

Fire Insurance

Organizations that forbid smoking on their premises should be in a good position to bargain for reduced accident and fire insurance premiums.

Lower Maintenance Costs

Maintenance costs are lower in a smoke-free environment -- no ash tray cleaning, dusting desktops is easier, less need for carpet and drapery cleaning, less soiling of upholstered furniture, and less accumulation on windows.

Damage to equipment and furniture is increased when smokers are in a workplace.

At Merle Norman Cosmetics, switching to a smoke free workplace reduced yearly janitorial charges by \$13,500 a year.

Ventilation Costs

Ventilation rates must be increased where smoking is present.

For acceptable air quality, a turnover of five cubic feet per minute is required. This turnover must be increased to 20 cubic feet per minute where smoking is present. The additional cost per smoker per year amounts to \$27.57 ("The Smokefree Workplace").

Application Process

Private employers turn down job applications on any basis except those specifically protected by statute - race, religion, sex, national origin, union membership and certain physical handicaps.

An employer merely needs to show a rational justification for its non-smokers only policy, such as a desire to minimize costs and protect other employees from hazardous substances during working hours.

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Can Smokers Be Fired?

In "The Smokefree Workplace," there is the following concluding paragraph on this subject: "Employers have a right, indeed a duty, to protect safety; smoking poses a foreseeable danger to the smoker to property and to other persons. Discharges for smoking do not involve prohibited discrimination. An employer has the right to control what is done on duty time."

The book cites specific court rulings: "In the case of Austin vs. Tennessee 179 US 343 (1900), the Supreme Court ruled there is no right to smoke - thus upholding a total ban of cigarettes in that case."

Conclusions

From the standpoint of decreased employer earnings, decreased employee productivity, increased life insurance and health insurance costs, increased fire insurance premiums, higher maintenance costs, increased ventilation costs and the increased cost of replacing experienced workers, it would be prudent for the employer not to hire smokers.

In view of the above, the day is fast approaching when smokers will be hard pressed for employment.

Court rulings uphold the rights of employers to prohibit smoking on its premises and to dismiss those who do so and hire only non-smokers.

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Things To Come

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Clinically Relevant Risk Factor Management of Cardiac Disease. University Plaza, Springfield, MO. Sponsored by the Shealy Institute for Comprehensive Health Care, Springfield, MO. Fees: \$185.00 both days; \$110.00 one day. Eleven hours of CME credits available. For more information, contact Susan Robords at (417) 865-5940.

February 21-24

Rhinoplasty. Location and fees to be announced. Sponsored by the Washington University School of Medicine, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862.

February 28-March 2

Advances in Pulmonary and Critical Care Medicine. Round Hill Resort, Montego Bay, Jamaica. Sponsored by the Southern Medical Association. CME Category I credit available. For more information, call LaDonna Nail at 1-800-423-4992.

February 28-March 2

Innovations in Radiological Techniques and Technologies. The Princess Hotel, Acapulco, Mexico. Sponsored by the Southern Medical Association. CME Category I credit available. For more information, call LaDonna Nail at 1-800-423-4992.

March 2-7

ASCP/CAP 1991 Spring Meeting. Opryland Hotel, Nashville, TN. Sponsored by the American Society of Clinical Pathologists, in conjunction with the College of American Pathologists. For more information, call 1-800-621-4142.

March 15-17

Office Management of Infectious Diseases. Sandestin Beach Hilton, Destin, FL. Sponsored by the Southern Medical Association. CME Category I credits available. For more information, call LaDonna Nail at 1-800-423-4992.

April 10-13

Treatment of Surgical Spine Disease, The Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Washington University School of Medicine. For more information, call Cathy Caruso at 1-800-325-9862.

April 19-21

Focus on the Athletic Patient. The Cottages, Hilton Head, SC. Sponsored by the Southern Medical Association. CME Category I credits available. For more information, call LaDonna Nail at 1-800-423-4992.

April 19-21

Advances in Surgical Techniques and Technologies. The Homestead, Hot Springs, VA. Sponsored by the Southern Medical Association. CME Category I credits available. For more information, call LaDonna Nail at 1-800-423-4992.

April 21-23

8th National Conference on Prescription Medicine Information and Education. Omni Shoreham Hotel, Washington DC. Sponsored by the National Council on Patient Information and Education. For more information, call (202) 347-6711.

April 26-28

Diagnostic Dilemmas in Cardiology. Kingston Plantation, Myrtle Beach, SC. Sponsored by the Southern Medical Association. CME Category I credits available. For more information, call LaDonna Nail at 1-800-423-4992.

April 30-May 2

Molecular Basis of Bone Cell Physiology: Transcellular Signaling, The Sheraton West Port Inn, St. Louis, MO. Sponsored by the Washington University School of Medicine. For more information, call Cathy Caruso at 1-800-325-9862.

May 1-3

Protection for Research Risk, The Hyatt Regency, Union Station, St. Louis, MO. Sponsored by the Washington University School of Medicine. For more information, call Cathy Caruso at 1-800-325-9862.

May 3-5

Diagnostic Dilemmas in Neurology and Psychiatry. The Grand Hotel, Point Clear, AL. Sponsored by the Southern Medical Association. CME Category I credits available. For more information, call LaDonna Nail at 1-800-423-4992.

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New Members

BENTON COUNTY

Mulchin, Walter L., Emergency Medicine, Bentonville. Born November 27, 1944, Meadville, PA. Medical education, Temple University Medical School, Philadelphia, PA, 1972. Internship, US PHS Hospital, New Orleans, LA, 1973. Practice experience, 17 years. Board certified.

Revard, Ronald E., Internal Medicine/Cardiology, Bentonville. Born January 4, 1951, Oklahoma City. Medical education, UAMS, Little Rock, 1982. Internship/residency, UAMS, 1985. Practice experience, 5 years. Board certified.

CRAIGHEAD COUNTY

Chandler, David R., Orthopedics, Jonesboro. Born December 17, 1955, Colorado. Medical education, University of Southern California, Los Angeles, 1982. Internship/residency, Los Angeles County USC Medical Center, 1987. Practice experience, 2 years. Board eligible.

FAULKNER COUNTY

Pullman, Norman K., Plastic Surgery, Conway. Born June 15, 1921, Omaha, NE. Medical education, Creighton University School of Medicine, Omaha, NE, 1945. Internship, St. Joseph Hospital, Denver, CO, 1946 and Methodist Hospital, Peoria, IL, 1949. Residency, Wesley Medical Center, Wichita, KS, 1952 and St. Anthony Hospital, Oklahoma City, OK, 1960. Practice experience, 40 years. Board certified.

JEFFERSON COUNTY

Plaza, Jesus A., Anesthesia, Pine Bluff. Born March 26, 1937, Port-of-France, Martinique. Medical education, Universidad Central of Madrid, Spain, 1962. Internship, St. Joseph Mercy Hospital, Detroit, MI, 1967. Residency, Sinai Hospital, Detroit, MI, 1974. Practice experience, 16 years. Board eligible.

OUACHITA COUNTY

Floss, Robert A., Family Practice, Hampton. Born November 28, 1943, Toledo, OH. Medical education, Medical College of Ohio, Toledo, 1986. Residency, Flower Memorial Hospital, 1989. Board certified.

POLK COUNTY

Page, Merlyn B., OB/GYN, Mena. Born August 30, 1930, Poteau, OK. Medical education, UAMS, 1965. Internship/residency, Hillcrest Medical Center, Tulsa, OK, 1969. Practice experience, 31 years. Board certified.

POPE COUNTY

Turner, Kenneth B., Family Practice, Atkins. Born February 7, 1957, Memphis, TN. Medical education, UAMS, 1983. Internship, LSU Medical Center, Shreveport, LA, 1984. Residency, AHEC Fort Smith, 1987. Practice experience, 3 years. Board certified.

RESIDENT

Tippin, Philip B., Family Medicine, Tulsa, OK. Born June 5, 1958, Russellville. Medical education, St. George's University School of Medicine, Grenada, West Indies, 1988. Internship/residency, University of Oklahoma College of Medicine, Tulsa, 1990. Board certified.

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Use of Psychotropic Drugs in Children

January 31, 1991, 12:00 noon. Sponsored by AHEC-Fort Smith and presented by John Sadler, M.D. Seventh floor dining room, Sparks Regional Medical Center.

Immunization Update

February 6, 12:30 p.m. Sponsored by AHEC-Fort Smith and presented by Charles Floyd, M.D. Medical Library, Sparks Regional Medical Center.

Evaluation of Murmurs in Children

February 20, 12:00 noon. Sponsored by AHEC-Fort Smith and presented by J.B. Norton, M.D. Seventh floor dining room, Sparks Regional Medical Center.

Annual Cardiovascular Update

February 22. Presented by the Baptist Medical Center, in the J.A. Gilbreath Conference Center. For more information, call BMC Medical Education at 227-2672.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

Continuing Medical Education Luncheon, second and fourth Friday, 12:30 p.m. AMI Ozark-Quapaw Room. One Category I credit per meeting.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), third Wednesday, 12:30 p.m., Conference Room, Building 1, VAMC
Medical Grand Rounds, Fridays, 12:00 noon, VAMC

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Faculty Resident Seminar, third Thursday, 12:00 noon, Sturgis Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Building, Room 457
Infectious Disease Conference, second Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Building, Auditorium
Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., 2nd Floor Classroom
Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, 2nd Classroom
Pediatric Research Conference, first Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

Sleep Disorders Case Conference, second and fourth Thursday. Video production conference room. Lunch provided.
Interdisciplinary AIDS Conference, second Friday, 12:00 noon. LaHarpe Room. Sandwich buffet is served.
Cancer Conference, third Thursday, 12:00 noon, Laboratory Conference Room. Lunch is provided.
Hematology-Oncology Conference, second Thursday, 12:00 noon. Lunch is provided.
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Southwestern Bell/Arkla Room. Refreshments are provided.
Pulmonary Conference, second and fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla Room. Sandwich buffet is served.
Journal Club, every Tuesday, 12:00 noon, Lunch is provided.
GYN Surgery Cancer Conference, second Monday, 12:00 noon. Lunch is provided.
Joint Tumor Conference, first Wednesday, 12:00 noon. CARTI Auditorium. Lunch is provided.

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., Conference Room 1
GI Conference, fourth Friday, 12:00 noon. Lunch is provided.
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lectures and case presentations. A light lunch is provided.
Pathology Conference, first Tuesday, 3:00 p.m., Pathology Library
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch is provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC Oncology Forum, fourth Thursday, 4:00 p.m., UAMS ACRC 2nd Floor Conference Room, 1.5 credits
Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
Anesthesia Morbidity and Mortality Conference, second and fourth Tuesdays, 6:45 a.m.; first, third and fifth Thursdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy
Cardiothoracic Surgery Conference, first Thursday, 8:00 a.m., location varies
Child Psychiatry Clinical Case Conference/Research Review, most Fridays, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room
Dermatopathology Conference, Tuesdays, 8:00 a.m., UAMS Education Building, Room G/108 A&B
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon, UAMS Education Building, Room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Building, Room G/110A&B
Emergency Medicine Grand Rounds 1, third Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Grand Rounds 2, third Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology Conference Room, #M1/293.
Hematology Fellow's Forum, second, third, and fourth Fridays, 8:15 a.m., ACRC Betsy Blass Conference Room
Hematology/Oncology Clinical Problems Conference, Thursdays, 8:15 a.m., LRVA Pathology Conference Room
Interdisciplinary Gynecologic Cancer Conference, Fridays, 12:30 p.m., UAMS Education Building, Room G106 A&B
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., St. Vincent Infirmary Education Bldg., Arkla/Bell Room
Little Rock Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC Conference Room three times per month, CARTI Auditorium one time per month
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Building, Room G/131A&B
Medicine Research Conference, three Wednesdays per month, 4:30 p.m. Shorey Building, Room 3S06
Neurology Clinical Case Conference, Thursdays, 8:00 a.m. VAMC-LR Room 2D109
Neuropathology Conference, Thursdays, 10:00 p.m. UAMS Morgue
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Ob/Gyn Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Building, Room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, Room 3/150, 2 credit hours
Orthopaedic Basic Science Conference, occasional Tuesdays, 11:00 a.m., UAMS Education Bldg., Room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Building, Room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Building, Room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Building, Room B/135
Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Shorey Auditorium
Surgery Basic Sciences Conference, first Saturday, 7:30 a.m., ACRC 2nd floor conference room
Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room
Surgery Morbidity and Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room
Surgery Resident Case Conference, second, third, fourth, fifth Saturday, 7:30 a.m., ACRC 2nd floor conference room
Surgery Staff/Clinical Case Conference, alternating Tuesdays, 7:00 a.m., UAMS Education Building, Room G/141
Surgery Vascular/Radiology Conference, Tuesdays, 5:00 p.m., VAMC-LR Radiology Conference Room
Surgery Vascular Teaching Conference, Thursdays, 3:00 p.m., VAMC-LR Radiology Conference Room.
Urology Basic Sciences Conference, second Wednesday, 5:00 p.m., UAMS Education Building, Room G/106A&B
Urology Clinical Didactic Conference, third Tuesday, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
Urology Core Conference, once or twice monthly, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
Urology Grand Rounds, second and fourth Tuesday, 5:00 p.m., VAMC-LR (4D)
Urology Morbidity and Mortality Conference, last Wednesday, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
Urology Teaching Conference, once or twice monthly, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
Uro-Radiology Conference (Urologic Imaging), once monthly, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
VA Chest Conference (combined Surgical/Medical Chest Conference), alternating Mondays, 12:15 p.m., VAMC-LR, Room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine Conference Room, Room 1D173
VA Geriatric/Gerontology Research Conference, Wednesdays, 3:15 p.m., VAMC-LR, Room 1E123
VA Hematopathology Conference, Wednesdays, 3:00 p.m., VAMC-LR Pathology Conference Room
VA Lung Cancer Conference (combined Medical/Surgical Lung Cancer Conference), Tuesdays, 3:00 p.m., VAMC-LR, Room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-LR, Building 68
VA Medicine-Pathology Conference, Tuesday, 2:00 p.m., VAMC-LR, Room 2D109
VA Medicine Service Resident's Clinical Case Conference, Fridays, 12:00 noon, VAMC-LR, Room 2A109

VA Physical Medicine and Rehab Grand Rounds, fourth Friday, 11:00 a.m., VAMC-NLR Building 68, Room 118 or Arkansas Rehab Institute

VA Psychological Assessment Conference, Tuesdays, 3:00 p.m., VAMC-LR & NLR Psychology Department, 1.5 credit hours

VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, Room 2D109, 1.25 credit hours

VA Topics in Rehabilitation Medicine Conference, Thursdays, 8:00 a.m., VAMC-NLR Building 68, Room 118

VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology Conference Room

EL DORADO - AHEC

Behavioral Sciences Conference, first and fourth Friday, 12:30 p.m., AHEC - South Arkansas.

Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital

Gynecology-Pathology Conference, second Friday, 12:30 p.m., AHEC-South Arkansas

Internal Medicine Conference, first, second and fourth Wednesday, 12:30 p.m., AHEC-South Arkansas

Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas

Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas

Obstetrics-Gynecology Conference, fourth Thursday, 12:30 p.m., AHEC-South Arkansas

Surgical Conference, first, second and third Monday, 12:30 p.m., AHEC-South Arkansas

Tumor Clinic, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

Behavioral Sciences Conference, third Wednesday, 12:00 noon, Washington Regional Medical Center

City Hospital Staff Medical Meeting, second Friday, 12:00 noon, Fayetteville City Hospital

Family Medicine Conference, first, third, fourth Thursday; fourth Wednesday; second Thursday (odd months) AHEC-NW, 241 W. Spring, Fayetteville

Interesting Case Conference, 1st and 3rd Friday, 12:00 noon, Fayetteville City Hospital

Medicine Conference, first and third Tuesday, 12:00 noon, Washington Regional Medical Center

OB/GYN Conference, February 14, 12:00 noon, AHEC Conference Room

Pediatric Conference, second Wednesday, 12:00 noon, Washington Regional Medical Center

Radiology Conference, February 6, 12:00 noon, Washington Regional Medical Center

Nutrition Conference, January 2, 12:00 noon, Washington Regional Medical Center

Surgery Conference, second Tuesday, 12:00 noon, Washington Regional Medical Center Fulbright Board Room

FORT SMITH - AHEC

Internal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center

Neuroradiology Conference, third Wednesday, 12:00 noon, St. Edward Mercy Medical Center

Pediatric Cardiology, November 21, 12:00 noon, Sparks Regional Medical Center, 7th floor dining room

Issues in Ventilator Weaning, November 28, 12:00 noon, Sparks Regional Medical Center, 7th floor dining room

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first and third Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.

Arkansas Methodist Hospital CME Conference, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.

Chest Conference, second Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided

Craighead/Poinsett Medical Society, first Tuesday, 7:00 p.m. Jonesboro Country Club

Eaker AFB CME Conference, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria

Independence County Medical Society, second Tuesday, 7:30 p.m., Batesville Country Club, Batesville

Interesting Case Conference, fourth and fifth Tuesday, 12:00 noon, St. Bernards Dietary Conference Room. Lunch provided.

Jackson County Medical Society, third Thursday, 7:00 p.m., Newport Country Club, Newport

Kennett CME Conference, third Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO

Methodist Hospital of Jonesboro CME Conference, second Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro

Neuroradiology Conference, third Friday, 12:00 noon, St. Bernards Dietary Conference Room. Lunch provided.

Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.

Pocahontas CME Conference, third Wednesday, 12:00 noon and 7:30 p.m., Randolph County Medical Center Boardroom

Tumor Conference, 2nd Thursday, 4th Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided

Walnut Ridge CME Conference, third and last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria

White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

PINE BLUFF-AHEC

Behavioral Science Conference, first and third Thursday, 12:00 noon, Jefferson Regional Medical Center

Chest Conference, second and fourth Friday, 12:00 noon, Jefferson Regional Medical Center

Family Practice Conference, first and fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center

Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center

Internal Medicine Conference, second and fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center

Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second and fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Neuro-Radiology Conference, first and third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

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AMS Newsmakers

Tom Benton, M.D., a family medicine physician with the Ozarks Medical Center practicing in Salem at the Benton Clinic, has been named an Associate of the University of Arkansas for Medical Sciences.

Michael Coleman, M.D., member of and founder of nephrology at the Holt-Krock Clinic, has been listed in the 22nd edition of Marquis Who's Who in the South and Southwest for his continued medical research in the field of osteomalacia bone disease. He has been honored by Who's Who in America for the past 10 years.

Neil Compton, M.D., a retired physician and active environmentalist in Bentonville, has been honored as one of the 56 national award recipients of the first annual Teddy Roosevelt Conservation Award. The award was presented by President George Bush.

James T. Crider, M.D., of Harrison, has been named a Fellow of the American Academy of Family Physicians.

Robert E. Elliot, M.D., of Searcy, has been honored by the American Cancer Society, Arkansas Division, as "The Medical Volunteer of the Year" at its annual meeting. Dr. Elliot was honored for his medical contributions to cancer control in the state.

David D. Fried, M.D., of Mena, was recognized for 41 years of continued membership in the American Academy of Family Physicians at its recent convention.

Luis Garcia, M.D., a family physician with the Garcia Medical Clinic of Crossett, has been an Associate of the University of Arkansas for Medical Sciences.

Jean C. Gladden, M.D., of Harrison, was recently installed at an honorary life member of the board of directors of the American Cancer Society, Arkansas Division, at its annual meeting. Dr. Gladden has served as past president of the board and as national medical delegate.

Geoffrey Goldsmith, M.D. has been named as the new chairman of the Department of Family and Community Medicine at the University of Arkansas for Medical Sciences.

Ben Saltzman, M.D., of Little Rock, was recently installed at an honorary life member of the board of directors of the American Cancer Society, Arkansas Division, at its annual meeting. Dr. Saltzman has served as past president of the board.

Tom Tvedten, M.D., a general practice physician in Lake Village and is on the staff of the Chicot Memorial Hospital, has been named an associate of the University of Arkansas for Medical Sciences.

Timothy Webb, M.D., of Hot Springs, was honored by the American Cancer Society, Arkansas Division, as the "Unit Volunteer of the Year."

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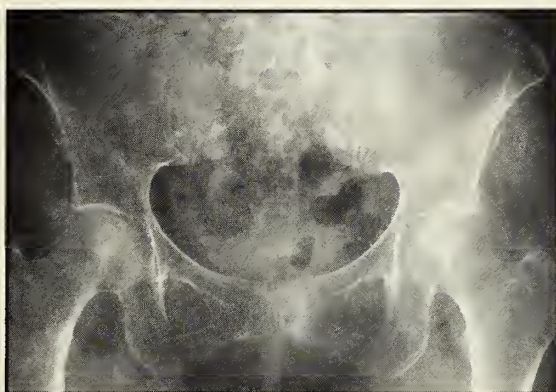
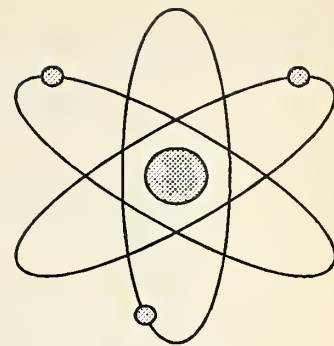
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Radiological Case of the Month



Figures 1. AP pelvis

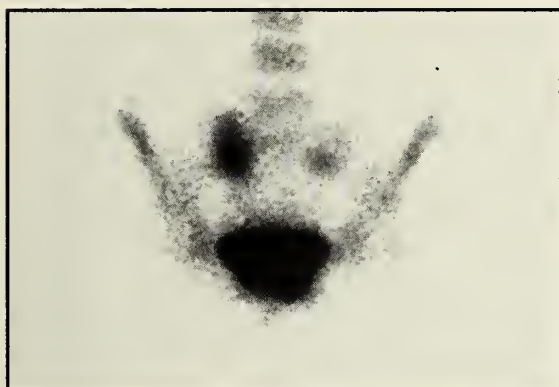


Figure 2a & 2b. Anterior and posterior bone scan of the pelvis

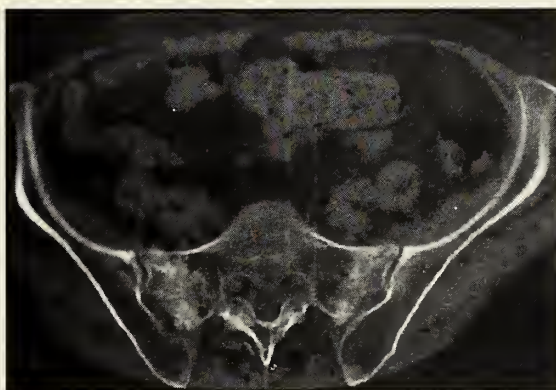


Figure 3. Bone algorithm CT scan of the sacroiliac joint

History:

This 70 year-old woman presented with acute low back pain and left hip pain following minor exertion. She has a history of polymyositis treated with Prednisone and Imuran.

Insufficiency Fractures of the Sacrum and Left Pubis

Findings:

The AP pelvis radiograph reveals subtle sclerosis in the right sacrum and left symphysis pubis. The CT scan reveals bilateral sacral sclerosis with disruption of the anterior left sacral cortex. The radionuclide bone scan demonstrates abnormal linear increased tracer accumulation in the right sacrum and inferior left sacrum, as well as focal abnormal tracer accumulation in the left symphysis pubis.

Discussion:

Insufficiency fractures of the sacrum, acetabulum and symphysis pubis are not an uncommon cause of low back pain and leg pain in elderly women.¹ They occur when the elastic resistance of bone is inadequate to withstand the stresses of normal activity. The decreased resistance is usually secondary to osteoporosis, and this condition tends to be limited to postmenopausal women. Radiation therapy, rheumatoid arthritis and steroid therapy are common exacerbating conditions.²

Sacral insufficiency fractures are difficult to diagnose. The findings on plain films are subtle and easily overlooked, as the sacrum is a complex anatomic region and overlying bowel gas or calcified iliac vessels may obscure the characteristic linear sclerosis. Plain film diagnosis may be impossible in early cases, as there is a variable delay in the development of endosteal callus following symptoms.²

The CT findings are characteristic, but are easily dismissed if bone window settings are not employed. Sclerosis, with or without cortical disruption, is evident in a vertical distribution just lateral to the transverse processes, paralleling the sacroiliac joints.^{2,3} The radionuclide bone scan findings are also characteristic with increased tracer accumulation in an identical vertical distribution. When bilateral, this produces the classic "H" sign. Additional fractures in the spine or pubis are evident on the bone scan in approximately 75% of patients. The bone scan will often be abnormal prior to the plain films.⁴

Differential considerations include post-radiation changes and metastatic disease. Post-radiation sclerosis should be diffuse. Awareness and recognition of the characteristic radiographic appearance of sacral and parasymphyseal insufficiency fractures should allow differentiation. If doubt exists, CT will be helpful to look for signs of metastases including a soft tissue mass or frank bony destruction. Biopsy should not be necessary.

References

1. Lowrie H. Spontaneous osteoporotic fracture of the sacrum: an unrecognized syndrome of the elderly. JAMA 1982; 248:715-717.
2. Cooper KL, Beabout JW, Swee RQ. Insufficiency fractures of the sacrum. Radiology 1985; 156:15-20.
3. Davies AM, Evans NS, Struthers GR. Parasymphyseal and associated insufficiency fractures of the pelvis and sacrum. Brit J Radio 1988; 61:103-108.
4. Ries T. Detection of osteoporotic sacral fractures with radionuclides. Radiology 1983; 146:783-785.

Editor and contributor: Steven R. Nokes, M.D., is in private practice and is affiliated with Radiology Consultants in Little Rock.

Contributor: Charles M. Boyd, M.D., is in private practice and is affiliated with Radiology Consultants in Little Rock.

Contributor: Thomas M. Kovalski, M.D., is in private practice and is affiliated with the Little Rock Diagnostic Clinic.

Editor: David Harshfield, M.D., chief of the radiology service at the Veterans Administration Hospital in Little Rock.

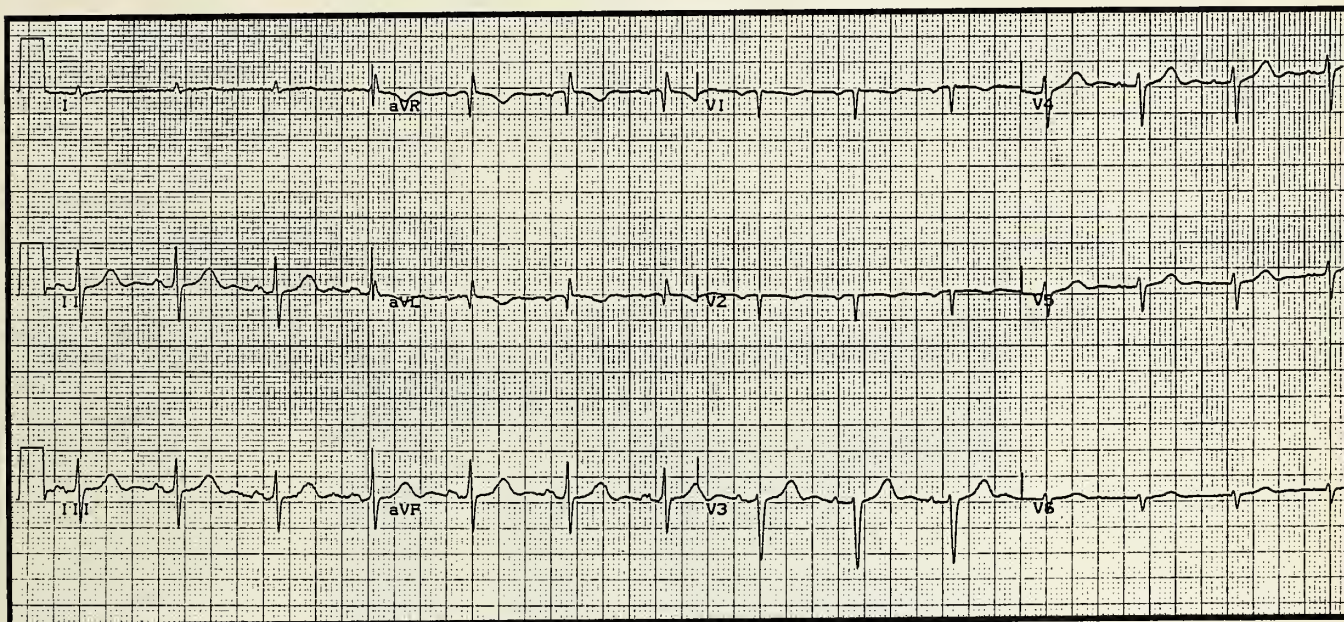


Electrocardiogram of the Month

Jon P. Lindemann, M.D.
UAMS Division of Cardiology
Little Rock, Arkansas

CLINICAL HISTORY:

This record was obtained from a 69 year-old male admitted for evaluation of cerebrovascular disease. He has a history of systemic hypertension and chronic obstructive lung disease with a greater than 50 pack-year history of cigarette smoking. There is no recorded history of symptomatic coronary artery disease. The computerized interpretation of this record is "Normal sinus rhythm; septal infarct, age undetermined; possible lateral infarct, age undetermined; abnormal ECG." What do you think?



DISCUSSION:

Normal sinus rhythm is present. The P wave is isoelectric in I and upright in II and III, indicating a rightward axis. Large S waves are present in the inferior limb leads while QR complexes are inscribed in a VR and a VL. The precordial leads reveal QS complexes in V₁ and V₂, accompanied by negative P waves. "Poor R wave progression" is also present.

The presence of a QS pattern in V₁ and V₂ is indeed suggestive of anteroseptal infarction, but the clue to correct interpretation comes from the overall pattern. The combination of a vertical heart, right axis of the P wave, similar QRS morphology in a VR and a VL, and clockwise rotation ("poor R wave progression") suggest the presence of chronic pulmonary emphysema. Hyperinflation of the lungs with depression of the diaphragms, results in a vertical displacement of the heart. Thus, the position of the exploring precordial electrodes becomes superior relative to the position of the heart. Consequently, the QS complexes in V₁ and V₂ are so-called intracavitary potentials because the exploring electrode is "looking into the ventricles" from a relatively high precordial lead placement relative to the heart. This interpretation can often be confirmed by recording the precordial leads one interspace lower. The finding of upright P waves and at least partial normalization of the R waves in the precordial leads would confirm this explanation. On the other hand, tobacco smoking is an important risk factor for both COPD and coronary artery disease, so it is possible that anteroseptal infarction can occur in a patient with COPD.

Medicine in the News

Medical History Made in Arkansas

Doctors at Baptist Medical Center made medical history in Arkansas recently when they successfully used a new catheterization technique to help a heart patient.

The new technique was used to regulate the heartbeat of a 45-year-old woman who was suffering from a rhythm problem that caused her heart to beat too fast, destroying her heart muscle.

The procedure involves the destruction of a small artery to a portion of the conduction system which allows the heart to contract at excessive rates. Eliminating the flow of blood to this structure causes a small, controlled myocardial infarction, killing the muscle and that portion of the conduction system that allows this rhythm problem to exist.

For arrhythmia patients for whom the standard procedure is ineffective, the previous alternative was open heart surgery to destroy the conduction system or to

continue drugs that are only partially effective or produce side effects.

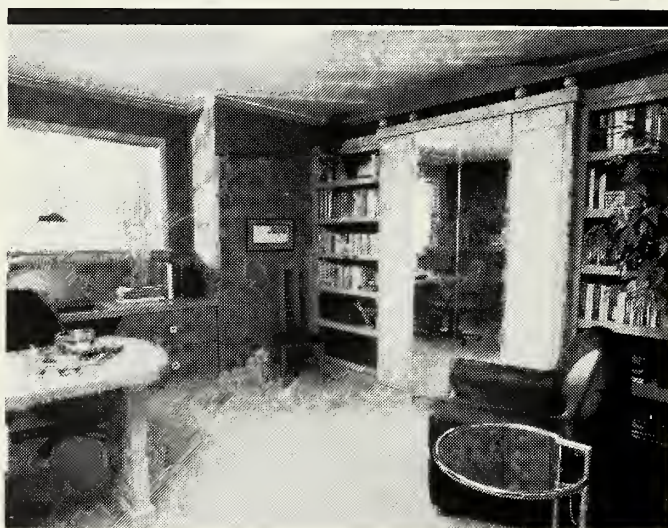
"...this new procedure allows doctors to insert a catheter directly into an artery and inject chemicals into the blood vessel, causing it to close. The end result is the same the DC current," said Dr. Steve Greer, one of the surgeons who performed the operation.

Health Care Access Foundation Update

As of November 1990, the Arkansas Health Care Access Foundation has provided free medical services to 2,180 medically indigent persons.

The program has 1,445 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.

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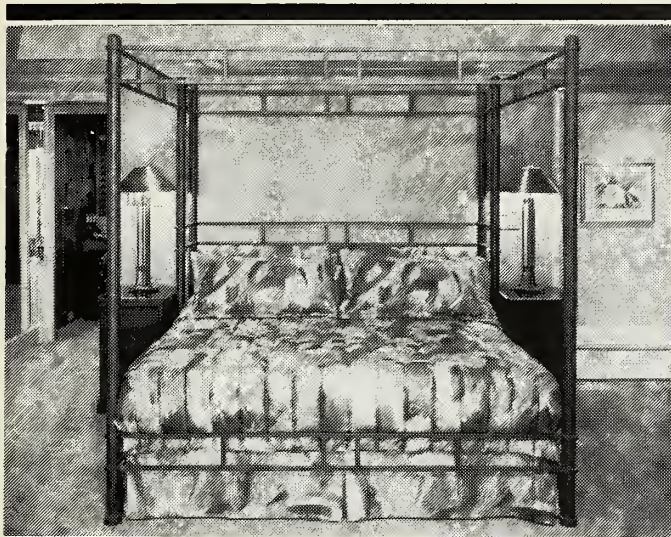
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In Memoriam

Robert P. Hughes, M.D.

Robert P. Hughes, M.D., of Texarkana, Texas, formerly of Okolona, died Friday, December 7, 1990. He was 81.

Dr. Hughes was a retired orthopedic surgeon at the Southern Clinic in Texarkana, TX, and a retired Army Medical Corps colonel. He was a member of the Arkansas Medical Society, the American Medical Association and a fellow of the American College of Surgeons.

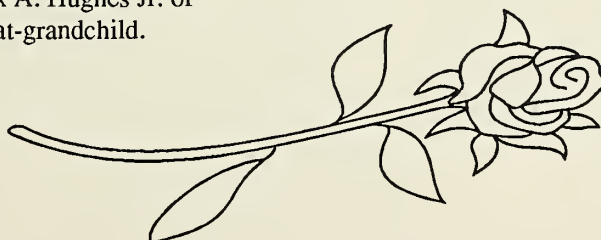
Dr. Hughes is survived by his wife, Margaret J. Hughes; a son, Robert P. Hughes Jr. of Fort Smith; two daughters, Bette Hughes Shoptaw and Margee Hughes Hall of Texarkana, TX; a brother, Felix A. Hughes Jr. of Memphis; 11 grandchildren; and a great-grandchild.

Ross E. Maynard, M.D.

Ross E. Maynard, M.D., of Pine Bluff, died Tuesday, November 27, 1990. He was 83.

Dr. Maynard was a member of the Arkansas Medical Society, past president of the Jefferson County Medical Society and the Arkansas Academy of Family Physicians. He was an Army veteran of World War II.

Dr. Maynard is survived by his wife, Marjorie Lovejoy Maynard; a daughter, Joy Maynard Lewis of Houston, TX; a granddaughter, and two brothers.



Gerberding, M.D., Julie L. . .

Fourth Annual AIDS Seminar

Julie Gerberding, M.D., of San Francisco, California, will be the afternoon speaker for the Arkansas Medical Society's Fourth Annual AIDS Seminar on Saturday, April 27, 1991. Dr. Gerberding's session has been incorporated as part of the program for the Specialty Section Meetings during the 1991 Annual Session.

This seminar is intended for all physicians and all specialties.

Dr. Gerberding is the Director of HIV Counseling and Testing Service at San Francisco General



"HIV infection is no longer an uncommon disease treated only by a few specialists. Many will treat, care and counsel HIV-infected patients and their families. AMS members need to attend this seminar."

*Joseph Beck, II, M.D.
Committee Chairman
AMS Committee on AIDS*

Hospital and is Assistant Professor of Medicine at the University of California. She has authored or co-authored articles and/or abstracts on HIV in the *New England Journal of Medicine*, 1985, 1986; *Journal of Infectious Disease*, 1987, 1989; *American Society for Microbiology*

Interscience Conference, 1987, 1989; and the AMA HIV Infection and Disease, 1989.

The afternoon program will also include a group panel, which will include Dr. Gerberding and Arkansas physicians.

The panel discussion will provide you an opportunity to ask about nosocomial infections in health care workers and other related matters.

The 1991 AIDS Seminar will begin at 9:00 a.m. as part of the Society's Annual Session program and will focus on the socio-economic aspect of AIDS. The seminar will provide CME Credit for attendees.

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Am Fam Phys 1987;36:133-140

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- Prolonged use may result in overgrowth of non-susceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon.

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- Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, serum-sickness-like reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.0013%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
- Stevens-Johnson syndrome, toxic epidermal necrolysis,

and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.

- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertension, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

Abnormalities in laboratory results of uncertain etiology.

- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
- Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Ceclor and Coumadin concomitantly.
- Abnormal urinalysis; elevations in BUN or serum creatinine.
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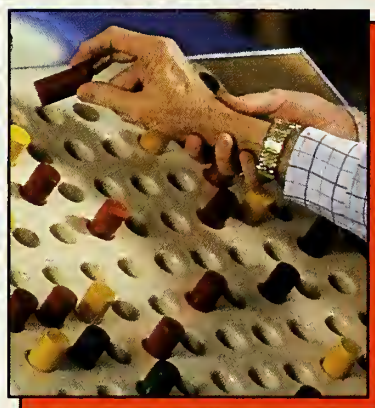
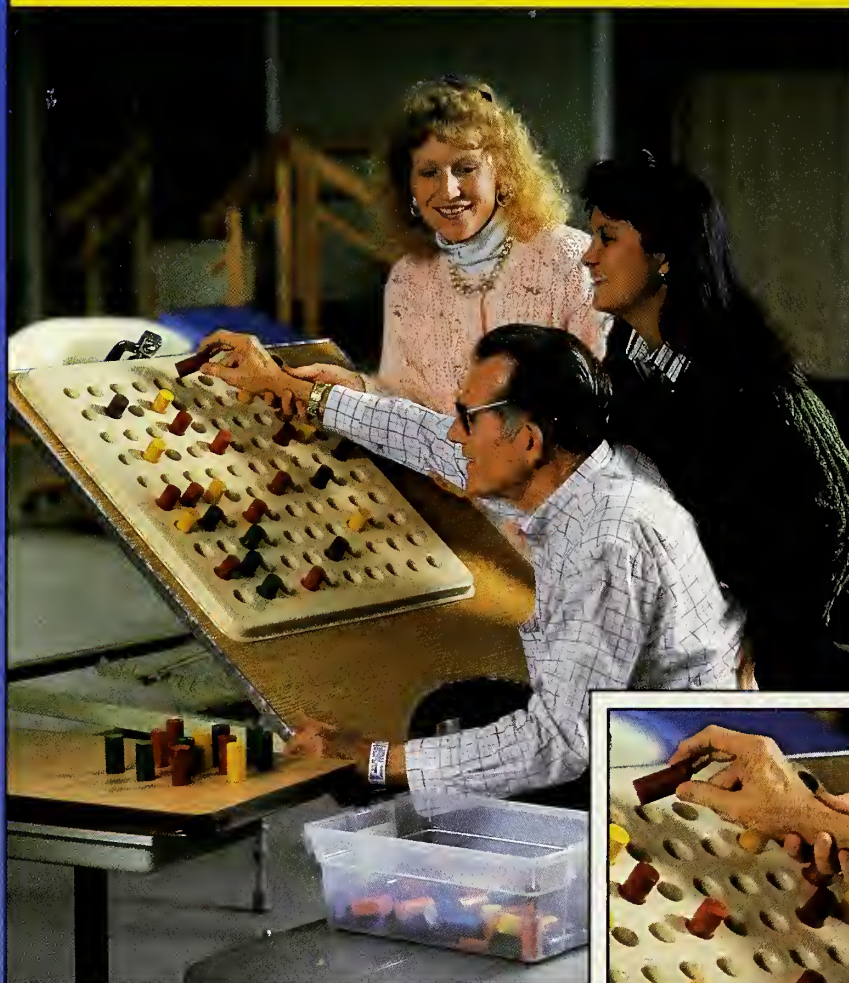
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Medical Student Indebtedness at UAMS

I. Dodd Wilson, M.D.*

Several years ago (August 1988), I wrote an editorial for this *Journal* regarding reasons for the declining interest in medicine as a career. Potential applicants were concerned, among many reasons, about the indebtedness students acquired during their medical school education and the realistic perception regarding reduced remuneration expected from medicine as a career. Although the number of applicants to medical school now is increasing, the problem of indebtedness of medical students remains. Our data at UAMS illustrate the national problem. In the Class of 1990, 82% or 101 students graduated with educational debt ranging from \$5,000 to over \$90,000 and averaging \$41,104. Thirty-four students have indebtedness of over \$50,000. Upon completion of medical school, the total class debt was \$4,151,426 and the estimated repayment of principal and interest will be \$11,562,000. Thus, the average student will repay approximately \$115,000, at terms far less favorable than a home mortgage.

How does this indebtedness affect our medical profession? The recognition of the extraordinarily high educational indebtedness undoubtedly causes some excellent applicants to forego a medical career. Once in medical school, indebtedness affects career choice. For example, the burden of debt plays an important role in making lower paying specialties such as primary care less attractive. The prospect of a large indebtedness affects the choice of applicants among colleges of medicine. Colleges with ample resources provide attractive four-year scholarship packages that recruit students elsewhere who might have matriculated at UAMS. Many of these excellent physicians will be lost to Arkansas.

In 1989-90, \$5,604,449 of financial aid was provided to our medical students; \$4,844,540 was in the form of loans and \$745,865 in the form of scholarships. Of the scholarships, \$491,650 was from the federal government and the remainder mostly from private and institutional sources. Our scholarships are too small a portion of our total financial aid.

We have three goals. The first is to improve our dept management counseling. The second is to reduce dependence on high interest loans. Two very expensive loans, called SLS and HEAL, make up \$1.2 million of our loan portfolio. These expensive loans result in repayment costs almost twice that of the other available loans. We have installed new computer software which allows each student to assess the effect of added borrowing on their eventual financial situation.

Our third and most important goal is to increase the percentage of financial aid represented by scholarships. Because federal government scholarships will not increase, there is a need for more private and institutional scholarships. During the past three years, the college has increased private and institutional scholarships from \$121,130 in 1987-88 to \$306,140 for the 1990-91 academic year. The number of scholarships went from 103 to 140. Much of this is due to the generous support of our alumni, their clinics, and other citizens of the state. Many alumni classes within our college have started scholarship funds. The AMA/ERF has been a generous contributor.

Members of the Arkansas Medical Society should help us to help deserving students meet their educational expenses. This can be done through direct contributions, trusts and bequests. We all want our students to have an attractive career and to feel less constrained by the need to pay off a huge educational debt while developing a practice and meeting the needs of their young families.

* Dr. Wilson is the dean of the College of Medicine at the University of Arkansas for Medical Sciences, Little Rock.



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Non-members: Watch for the complete schedule of events and a registration form in the Annual Session Digest appearing in the December 15, 1990, and January 1 and February 1, 1991, issues of *ANNALS OF INTERNAL MEDICINE*.

ACP

NuPRO - New Role for the PRO?

Russell G. Brasher, Ph.D.*

The PRO program may be due for fundamental changes in the next year or two. Several developments are occurring at the national level that could significantly alter both the program's basic role and the way it pursues its goals.

Institute of Medicine Recommendations

A major catalyst for change was the issuance of a report entitled "Medicare: A Strategy for Quality Assurance" by the prestigious Institute of Medicine of the National Academy of Sciences. The IoM report called on Congress to explicitly acknowledge the government's responsibility for ensuring the quality of care furnished to Medicare enrollees and the report recommended, in this regard, that Congress restructure the PRO program, redefine its functions, and implement a new program - the Medicare Program to Assure Quality (MPAQ).

The MPAQ would be concerned first and foremost with quality of care, not with utilization or cost control. Its operational model would be that of continuous quality improvement, focusing on problems in systems rather than in individuals and seeking to improve "average" quality rather than being preoccupied with outliers in the lowest range of the quality curve. The new Medicare Quality Review Organizations (MQROs), would maintain larger, more comprehensive data bases, would perform more systematic and sophisticated data analysis and statistical studies, and would provide feedback to providers and practitioners.

Uniform Clinical Data Set

Other developments are already in progress that also may have far-reaching effects on the PRO program. The Health Care Financing Administration is getting ready to field test a new data collection instrument, the Uniform Clinical Data Set (UCDS). The emphasis here is on the

clinical aspect, as distinguished from present data sets that have evolved basically from utilization or billing instruments. A single UCDS record of a hospital admission may have up to 1,600 data items and requires a nurse or other clinically knowledgeable individual about an hour and a half to abstract one medical record.

The UCDS is a prototype of the clinical data bases of the future. It is the type envisioned by the Institute of Medicine to be used by the MPAQ as described above, and it is also the type that can be used in longitudinal studies over time and in "outcomes assessment." HCFA also has a more immediate interest in the UCDS, involving the PRO program. In the field tests, a UCDS record will be keyed into a computer which will decide whether a physician should review the medical record. The computer will essentially take the place of the review coordinator.

Graphic Variations

Another project already under way is analysis of geographic variations in medical services utilization. Using large data bases, this population-based (i.e., epidemiologic) technique identifies small areas, such as counties, metropolitan areas, etc., with large variations in certain medical practices. A classic example is a locality with a tonsillectomy rate ten times that of a neighboring locality, with similar at-risk populations. HCFA has sponsored pilot projects in small area analysis with generally favorable results, including one in Arkansas on carotid endarterectomy. In their reliance on large data bases and sophisticated analysis, their concern with typical rather than aberrant performance, and their emphasis on education feedback rather than adversarial or punitive measures, these pilot projects exemplify many of the characteristics recommended by the IoM report.

These are some of the ideas that may shape a new PRO program in the near future. Collectively, they are being referred to humorously as "NuPRO" by some observers. Whatever name it carries, the new program may be very different from the one today.

* Dr. Brasher is the chief executive officer of the Arkansas Foundation for Medical Care, Inc., Fort Smith.

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Leo F. Drolshagen, M.D.*, John A. Worrell, M.D.***
Deland D. Burks, M.D.**, Gudron Durmon, R.T., RDMS**

Abstract

During a 30-month period, 7,531 obstetrical ultrasound examinations were performed on 3,624 fetuses at a community hospital. All fetuses were evaluated for congenital heart disease and 16 complex defects were identified. Only two of the cardiac defects had predisposing clinical factors or an elevated serum alpha-fetal protein. Discovery of cardiac defects in-utero permitted referral of the patients to tertiary care facilities when delivery was desired. This allowed prompt therapy by a pediatric cardiologist or cardiothoracic surgeon, if necessary.

Introduction

Congenital heart disease (CHD) is one of the most common fetal malformations with an estimated incidence of eight to nine per thousand live births. The most common anomalies include bicuspid aortic valve, mitral valve prolapse, ventricular septal defects, patent ductus arteriosus, pulmonic stenosis, and atrial septal defects.¹ Many of these abnormalities are not life threatening or severe enough to be recognized until late childhood or early adulthood. Others, however, in particular the complex cardiac defects, can be life threatening at birth and may require immediate therapy. The objective of this study was to identify severe cardiac defects in-utero, at our community hospital, so that the patients might be referred to a tertiary care center for delivery and appropriate treatment.

Material and Method

Retrospective review was conducted on 7,531 routine obstetrical ultrasound examinations performed over a 30-month period on 3,624 fetuses. After 16 weeks gestational age, all patients received a level 2 obstetrical ultrasound examination with analysis of all major fetal organs including the head, spine, heart, chest, abdomen, kidneys, bladder, and extremities. Routine four-chamber views of the fetal heart were obtained, most commonly after 20 gestational weeks and earlier when feasible. Additional views of the heart including ventricular outflow tract, short axis, and aortic arch were also obtained.

All complex cardiac anomalies that were identified were followed up with the patient's referring physician or with the pediatric cardiologist if the patient was sent to a tertiary care facility for therapy or delivery.

Indications for the obstetrical sonograms varied, with a large proportion of the studies ordered as a routine aspect of obstetrical care. We advocate obtaining a routine sonographic examination during the second trimester, at approximately 20-22 weeks gestational age. At that time, detailed fetal anatomic screening is feasible and fetal biometry gives a reasonable reliable gestational age.

Results

During the 2 1/2 years of this study, 16 complex cardiac anomalies were diagnosed. The cardiac anomalies are listed (Table I) including a fetus with tetralogy of Fallot (Fig. 1). In addition, other co-existing anomalies were discovered, including two fetuses with holoprosencephaly, a case of asplenia, one neural tube defect, one Klippel Feil deformity, and a case of bilateral renal agenesis.

Single cases of trisomy 21, trisomy 18 and 13 were also discovered in three patients. Only two of the 16 fetuses with cardiac anomalies had a positive maternal serum alphafetal protein study or other suspicious clinical findings such as maternal diabetes mellitus. Fetal cardiac defects were dis-

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covered in 3 patients referred because of non-cardiac fetal anomalies and the remainder were identified at routine screening.

At least one severe cardiac anomaly, a case of tetralogy of Fallot, was not diagnosed prenatally, although only a limited four-chamber view of the heart was obtainable in this third trimester fetus. One cardiac defect was correctly diagnosed as hypoplastic left heart syndrome, however, a coexisting pulmonary vein atresia was later identified at a tertiary care facility.

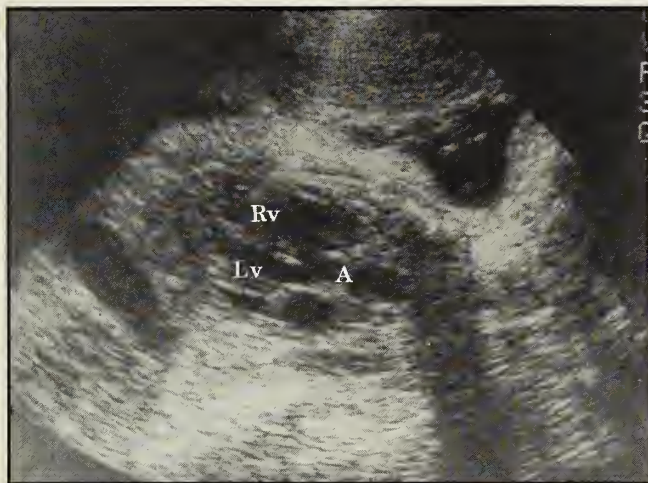


Figure 1. Long Axis View of Fetal Heart with Tetralogy of Fallot
A = Aorta; LV = Left Ventricle; RV = Right Ventricle

Two additional fetuses had prenatal echocardiography performed at tertiary care facilities substantiating the original sonographic diagnosis. Three fetuses had echocardiograms performed at a tertiary care center which did not substantiate our initial diagnosis but subsequent postnatal echocardiography confirmed the original diagnosis of heart disease.

There were seven live births in the study, including an infant with a hypoplastic left heart syndrome variant, who received a cardiac transplant. Three women elected to terminate the pregnancies and six perinatal deaths occurred. All live births had postnatal echocardiograms confirming the prenatal sonographic findings.

Discussion

Congenital heart disease (CHD) is thought to be caused by multiple factors. In approximately 2% of patients, environmental toxins are implicated, including maternal drug exposures such as amphetamines and lithium. Infections such as rubella, alcoholism, maternal diabetes mellitus, lupus erythematosus, and a positive family history for congenital heart defects are also associated with congenital heart disease. Approximately 7% of CHD is associated with a genetic abnormality such as trisomy 21 (50% affected), trisomy 18 (99% affected), trisomy 13 (90% affected), and

the XO (Turners) syndrome (35% affected).

In the United States, Silverman and Schiller were the first to propose routine sonographic evaluation of the fetal heart to reduce the frequency of unanticipated severe congenital heart disease. They and others have advocated the four chamber view as a requisite in screening the fetal heart.^{4,5,6,7}

By applying a systematic approach to the fetal heart, one can diagnose a significant percent of cardiac malformations prenatally.^{6,7} Fetal cardiac analysis should include evaluation of the position and axis of the fetal heart within the chest, identification of all four chambers and their relative size and contractility, evaluation of valve motion and atrio-ventricular connections, and evaluation of the ventricular outflow tracts.

Identification of a cardiac defect should prompt a careful search for other fetal structural anomalies; conversely, detection of non-cardiac fetal anomalies should prompt a careful evaluation of the heart. Amniocentesis should also be considered.

Detection of a severe congenital cardiac defect, occasionally as early as 16 weeks gestation in our experience, may raise ethical dilemmas for the patient and physician.⁸ In order to provide adequate parental counseling regarding prognosis, there must be reasonable certainty of the diagnosis. Complete sonographic analysis of some cardiac defects

Table 1
Complex cardiac anomalies discovered in 3624 fetuses

Findings	Number of Fetuses
Hypoplastic left heart syndrome or variants	5
Ventricular septal defects	3
Tetralogy of Fallot	2
Ebsteins anomaly	1
Tricuspid atresia	1
Double outlet right ventricle	1
Atrial septal defect with hypertrophy of ventricular septum	1
Dextrocardia with situs solitus	1

before the sixth month of gestation may be difficult. Often repeat sonography is essential or desirable to confirm or better define the abnormality. The parents must be given a thorough explanation, including genetic counseling. Parental desires regarding termination of pregnancy must be balanced against the certainty of diagnosis/prognosis, and the infant's welfare. Complex fetal cardiac defects are frequently lethal if untreated and decisions regarding expensive therapy, such as cardiac transplantation, may become difficult.

Conclusion

Severe congenital cardiac defects can, with meticulous sonographic techniques, be accurately diagnosed prenatally. Appropriate referral to pediatric cardiologists at tertiary care facilities can improve the prognosis of certain affected fetuses. Additional non-cardiac defects can be discovered in utero, including central nervous system and chromosomal abnormalities, which will alter or obviate the need for therapeutic intervention.

Acknowledgement

Many thanks to Mary Minden for her secretarial assistance and to the excellent ultrasound technologists at SEMMC for their technical expertise.

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Correction

In the January 1991 issue of *The Journal of the Arkansas Medical Society*, the name of the author of the *From Other Years* article, Basil Smith Cantrell, M.D., was incorrect. The correct author was James Beck, M.D.

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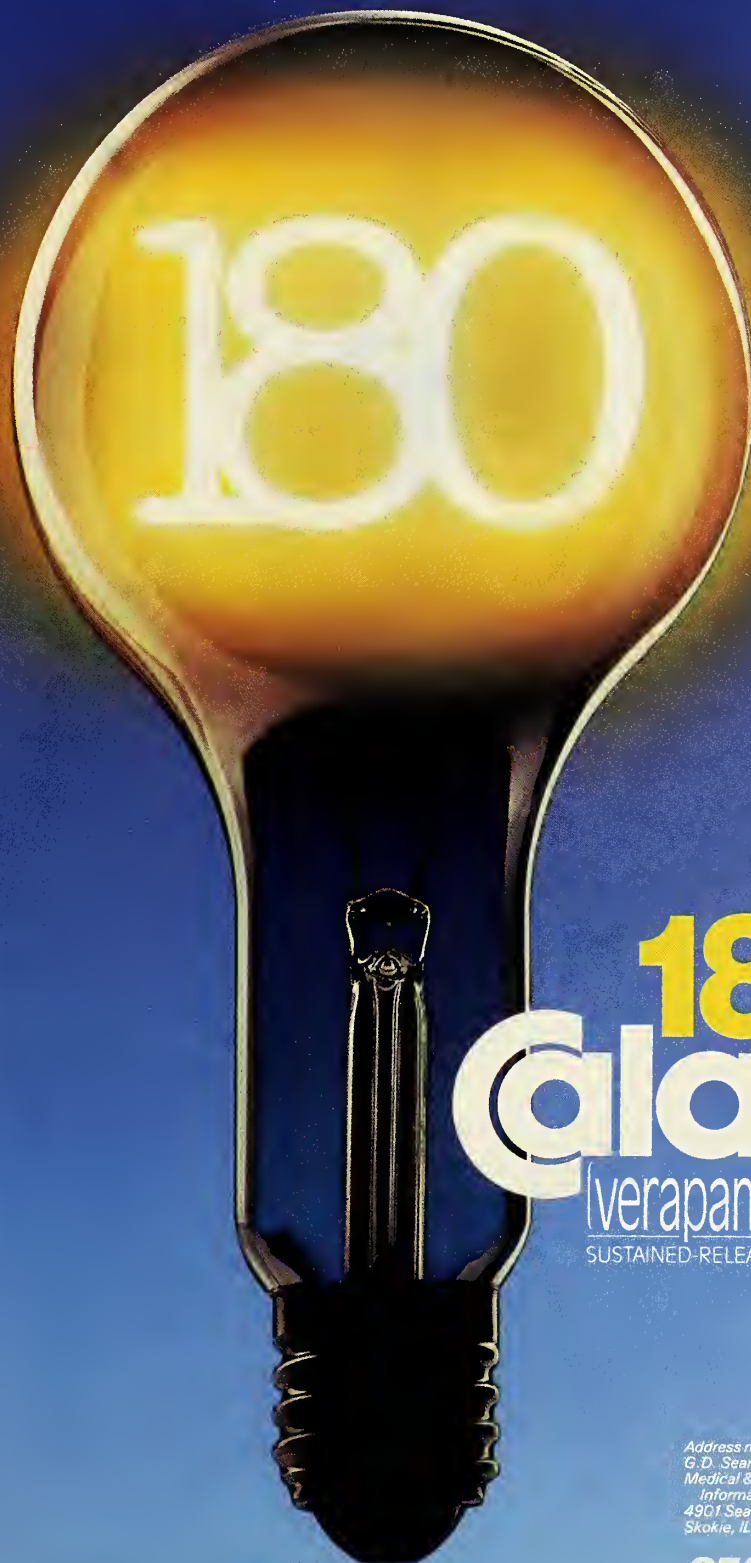
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AMS Efforts Evolve Into Strict Utilization Review Regulations

The Arkansas General Assembly passed Act 537 of 1989 for the purpose of regulating utilization review organizations. For the past 18 months, the Arkansas Department of Health has conducted a series of meetings and public hearings to draft rules and regulations in accordance with the Act. The Arkansas Medical Society played a major role in the adoption of these rules. Specific emphasis was given to written protocols; the names and qualifications of the reviews; definitive appeal procedures; and, reporting requirements. AMS members are encouraged to familiarize themselves with the new regulations for their information and protection.

RULES AND REGULATIONS FOR UTILIZATION REVIEW IN ARKANSAS 1990 ARKANSAS DEPARTMENT OF HEALTH

Part I. Authority and Purpose

The following Rules and Regulations for Utilization Review in Arkansas are duly adopted and promulgated by the Arkansas State Board of Health pursuant to the authority expressly conferred by the laws of the state of Arkansas in Act 537 of 1989.

The purpose of these rules and regulations is to promote the delivery of quality health care in a cost effective manner; foster greater coordination between payors and providers conducting utilization review activities; protect patients, business and providers by ensuring that private review agents are qualified to perform utilization activities and to make informed decisions on the appropriateness of medical care; and to ensure that private review agents maintain the confidentiality of medical records.

Part II. Definitions

For the purpose of these rules and regulations the following definitions shall apply:

A. Board means the State Board of Health.

- B. Certificate means a certificate of registration granted by the State Board of Health to a private review agent.
- C. Director means the Director of the Section of Health Facility Services and Systems.
- D. Hospital means any facility established for the purpose of providing inpatient diagnostic care, and treatment for two (2) or more unrelated persons for more than twenty-four (24) hours may not be conducted or maintained in this state without being licensed.
- E. Private Review Agent means a non-hospital affiliated entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of an Arkansas business entity or a third party that provides or administers hospital and medical benefits to citizens of this state including a Health Maintenance Organization or any entity offering health insurance policies, contracts or benefits in this state including a health insurer, non-profit health service plan, health insurance service organization, or preferred provider organization.
- F. Utilization Review means a system for reviewing the appropriate and efficient allocation of hospital resources and medical services given or proposed to be given to a patient or group of patients. More specifically, utilization review refers to preservice determination of the medical necessity or appropriateness of services to be rendered in a hospital setting either on an inpatient or outpatient basis, when such determination results in approval or denial of payment for the services. It includes both prospective and concurrent review and may include retrospective review under certain circumstances.
- G. Utilization Review Plan means a description of the standards governing utilization review activities performed by a private review agent.
- H. Utilization Review Representative means the person(s) in a physician office or hospital designated by the physician or hospital to provide the necessary information to complete the review process.

- I. Consulting Physician means a Medical Doctor, Doctor of Osteopathy, Dentist or Chiropractor who possess the degree of skill ordinarily possessed and used by members of his or her profession in good standing engaged in the same type of practice and specialty in the locality where the service under review occurred or in a similar locality.
- J. Certified Private Review Agent means a private review agent who meets all the criteria for certification as set forth in these rules and regulations, has paid all current fees, and has been assigned a certification number.

Part III. Private Review Agents - Application For Certification

- A. By December 31, 1990 or a date approved by the Director, a private review agent shall hold a certificate from the Director to conduct utilization review in this state.
- B. Completed application for certification shall be submitted to the Director within thirty (30) days of the receipt of the application form.
- C. A Private Review Agent seeking certification shall:
 - 1. Submit an application to the Director in a form that the Director requires;
 - 2. Pay an application fee of \$750 per year. This fee is payable in advance for both years of the certification (total \$1,500). This fee applies to the entity doing the review and not to the individual reviewer;
 - 3. Provide supporting documentation as required by this regulation.
- D. An application for certification shall be accompanied by all of the following:
 - 1. A utilization review plan which shall include any or all of the following components used by the private review agent to approve or deny payment or recommend approval or denial of payment in advance for proposed or delivered inpatient or outpatient care or retrospectively approve or deny under certain circumstances:
 - a. Elements of review such as:
 - 1) Preadmission;
 - 2) Admission;
 - 3) Preauthorization;
 - 4) Second surgical opinion;
 - 5) Discharge planning;
 - 6) Concurrent;
 - 7) Retrospective (only on request by the Director);
 - 8) Readmission review.

- b. Procedures for review including:
 - 1) Any form used during the review process;
 - 2) Time frames that shall be met during the review;
 - 3) A written protocol describing every aspect of the review process.
- c. A description and examples of review standards to be used for the review. This information as provided by Act 537 of 1989 shall be held in confidence and not disclosed to the public.
- d. Circumstances, if any, under which review may be delegated to a hospital utilization review program.
- e. The provisions, procedures, and time frames by which patients, physicians, or hospitals may seek reconsideration or appeal of adverse decisions by the private review agent including:
 - 1) A written protocol describing the appeals procedure;
 - 2) Any form which shall be completed during the appeals procedure;
 - 3) Time frames that shall be met during the appeal procedure;
 - 4) The names and qualifications of personnel making final appeal determinations. This information as provided by Act 537 of 1989 shall be held in confidence and not disclosed to the public.
- 2. The name, number, type, and qualification or qualifications of the personnel either employed or under contract to perform the utilization review. Private review agent will be required to adopt a specific credentialing process for physicians utilized by the private review agent. Any change in the medical director or any consulting physician or chiropractor physician shall be reported to the Director within thirty (30) days. Other personnel changes will be updated on a yearly basis.
- 3. The policies and procedures to ensure that a representative of the private review agent is accessible to patients and providers five (5) days a week during normal business hours in this state; and that a free telephone number be provided with adequate lines available and staffed. The procedure for handling after-hours inquiries shall be specified.
- 4. The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed.
- 5. A copy of the materials designed to inform appli-

cable patients and providers of the requirements of the utilization review plan.

6. A list (names and addresses) of the third party payors for which the private review agent is performing utilization review in this state. This information as provided by act 537 of 1989 shall be held in confidence and not disclosed to the public.

E. A certificate of registration is not transferable.

Part IV. Specific Assurances

The following specific assurances must be submitted by all applicants:

1. To assure confidentiality, a private review agent must, when contacting a physician's office or hospital, provide its certification number, the caller's name, and professional qualifications to the designated utilization review representative in the physician's office or hospital.
2. The entity providing utilization review will first contact the designated utilization review representative in the physician's office or hospital. Direct contact with the physician will be requested only when necessary information cannot be obtained from the designated representative. The designated utilization review representative must be reasonably available.
3. Any provider targeted for 100% concurrent review must be provided the reason, in writing, by the private review agent.
4. Only information necessary to complete the review process submitted under Part III will be collected.
5. An expedited appeals process shall be available. The physician of record shall have an opportunity to appeal that determination over the phone on an expedited basis. Utilization Review Organizations shall provide for reasonable access to their consulting physician(s) for such appeals.
6. Physician or designated utilization review representative shall be notified, as required by Federal Statute 18 U.S.C. S2511, when telephone conversations are being recorded and shall be provided a copy of the conversation upon request. The physician or utilization review representative who records any conversation with a private review agent shall have like responsibility.
7. For a period of six (6) months following the implementation date of these regulations, the certified private review agency shall send a copy of denials for any

covered service to the Director. At the end of this six (6) month period, copies of denials shall be furnished at the request of the Director.

8. Concurrent review should be initiated at a reasonable length of time following admission and at reasonable intervals thereafter. Utilization review organizations should not conduct routine daily review of all patients, but should base the frequency of the review on the patient's medical condition. The attending physician and the hospital should be informed of the certified length of stay and the next anticipated review encounter. Routine concurrent review generally should not be necessary earlier than twenty-four (24) hours prior to the lapse of the certified length of stay.
9. A review should be conducted by a physician advisor on a determination not to certify a continued length of stay due to questions of medical necessity or appropriateness. A consulting physician should be reasonably available by telephone to discuss the medical basis for that determination with the attending physician (e.g., criteria, protocols, medical literature).
10. When a determination is made not to certify continued length of stay, the utilization review organization should notify the physician and the hospital of this decision within twenty-four (24) hours by telephone, supplemented by written notification to the hospital, attending physician, and patient* within two (2) working days. This written notification should include an explanation of the principal reason(s) for the determination not to certify and the procedures to initiate an appeal of that determination if the patient so chooses.
11. If after an initial appeal or request for reconsideration, continued stay is not certified due to questions of medical necessity or appropriateness, the patient or provider should have the right to an additional review by another consulting physician of the appropriate medical specialty.

* The term "patient," when used throughout this document, refers to the patient, his/her representative, and/or the enrollee.

Part V. Private Review Agents - Renewal of Certification

- A. A certificate expires on the second anniversary of its effective date unless certification has been renewed for a two (2) year term.
- B. Before the certification expires, the certified private review agent may renew its certification for an additional two (2) year term, if the certified private review agent:

1. Otherwise is entitled to be certified;
 2. Pays to the Director the renewal fee of \$1,500; and
 3. Submits to the Director:
 - a. A renewal application on the form that the Director requires;
 - b. An update of information as required under Part III of these rules and regulations.
- C. The Director shall renew the certification of each certified private review agent if the requirements of these regulations are met.

Part VI. Private Review Agents - Reporting Requirements

The Director may establish reporting requirements to:

- A. Evaluate the effectiveness of private review agents;
- B. Determine if the utilization review programs are in compliance with the provisions of these rules and regulations.

Part VII. Private Review Agents - Denial or Revocation of Certification and Penalty

- A. The Director shall deny a certificate to an applicant if the Board finds that the applicant does not:
 1. Have available the services of a sufficient number of registered nurses, medical records technicians, or similarly qualified persons that are supervised by appropriate physicians to carry out its utilization review activities;
 2. Meet any applicable provisions of these rules and regulations relating to the qualifications of private review agents or the performance of utilization review the Board adopts relating to the qualifications of private review agents or the performance of utilization review;
 3. Have policies and procedures which protect the confidentiality of medical records in accordance with applicable state and federal laws;
 4. Make itself accessible to patients and providers five (5) working days a week during normal business hours in this state.
- B. The Director may revoke the certification of a private review agent if the Board finds that the agent:
 1. Does not comply with performance assurances;
 2. Violates any provision of these rules and regulations;
 3. Violates any regulation adopted under any provision of this subtitle;
 4. Fraudulently or deceptively obtains, attempts to obtain, or uses a certification;
 5. Fails to substantially meet the standards and qualifications adopted by the Director;

6. Fails to comply with the regulations adopted by the Board.
- C. Before denying or revoking a certificate, the Director shall provide the applicant or certificate holder:
 1. Written notice of the reasons for the denial or revocation;
 2. Thirty (30) days in which to supply additional information demonstrating compliance with the requirements;
 3. The opportunity to request a hearing in accordance with the Arkansas Administrative Procedures Act.
 - D. If the applicant requests a hearing, the Director shall send a hearing notice by certified mail, return receipt requested, at least thirty (30) days before the hearing.
 - E. An aggrieved party has the right to take direct judicial appeal of a final decision in accordance with the Arkansas Administrative Procedures Act.
 - F. A person who violates any provision of these regulations is guilty of a misdemeanor, and on conviction is subject to a penalty not exceeding \$1,000. Each day a violation is continued after the first conviction is a separate offense.

Part VIII. Private Review Agents - Exemptions

- A. The Director may waive the requirements of these rules and regulations for a private review agent that operates solely under contract with the federal government for utilization review of patients eligible for hospital services under Title XVIII of the Social Security Act (Medicare) and Title XIX (Medicaid).
- B. No certificate is required for utilization review by any Arkansas licensed pharmacist or pharmacy, or organizations of either, while engaged in the practice of pharmacy in this state.

Part IX. Health Insurance Plan - Insurer Issuing Health Insurance Policy - Group or Blanket Health Insurance Policy

All stated entities under Part III shall have a certificate in accordance with these rules and regulations or contract with a private review agent that has a Certificate of Registration. An insurer that does not meet the requirements of this section shall pay any person or hospital entitled to reimbursement under the policy or contract for claims where medical necessity of a covered benefit has been disputed.

Part X. Repeal

All provisions of these rules and regulations are amendatory to the Arkansas Code of 1987 Annotated.

Help For The Chemically Dependant Physician

The AMS Physicians' Health Committee

Joe L. Martindale, M.D.*

Who Are We?

The Arkansas Medical Society Physicians' Health Committee is a group of physicians dedicated to the diagnosis and treatment of our chemically dependent colleagues. We also deal with other health problems, both physical and emotional, that prevent doctors from practicing good medicine. Our authority to function is granted by the Council of the Arkansas Medical Society.

What Do We Do?

We investigate reported impairment and, if warranted, do an intervention. We select a treatment modality and then monitor through drug screens and personal contact for two years after treatment is completed. We are advocates for these physicians before the State Medical Board, hospital staffs and insurance companies during our monitoring period. The Physicians' Health Committee does not get involved in any legal actions.

How Do You Contact Us?

We have a 24 hour hotline: (501) 370-8221. If called, it will put you in touch with a Committee member. All information is kept strictly confidential. You cannot be held legally liable for reporting an impaired physician when such reporting is done in good faith and based on reasonable grounds. You are ethically and morally obligated to report physician impairment (see shaded box). You may report to us and the physician will not be subject to public scrutiny or you may report to the State Medical Board where all action is a matter of public record.

What is Our Relationship With the Board?

We have a good working relationship with the State Medical Board with strong support and mutual respect for what we each do. We will report physicians to the board



whom we have determined need help and refuse to comply with our recommendations. This can result in license suspension which then becomes public and must be reported to the National Practitioner Data Bank.

The National Practitioner Data Bank

Any reduction in hospital staff privileges or disciplinary action by the State Medical Board must be reported and is there forever. The Physicians' Health Committee is not required to report our actions to the Bank.

Conclusion

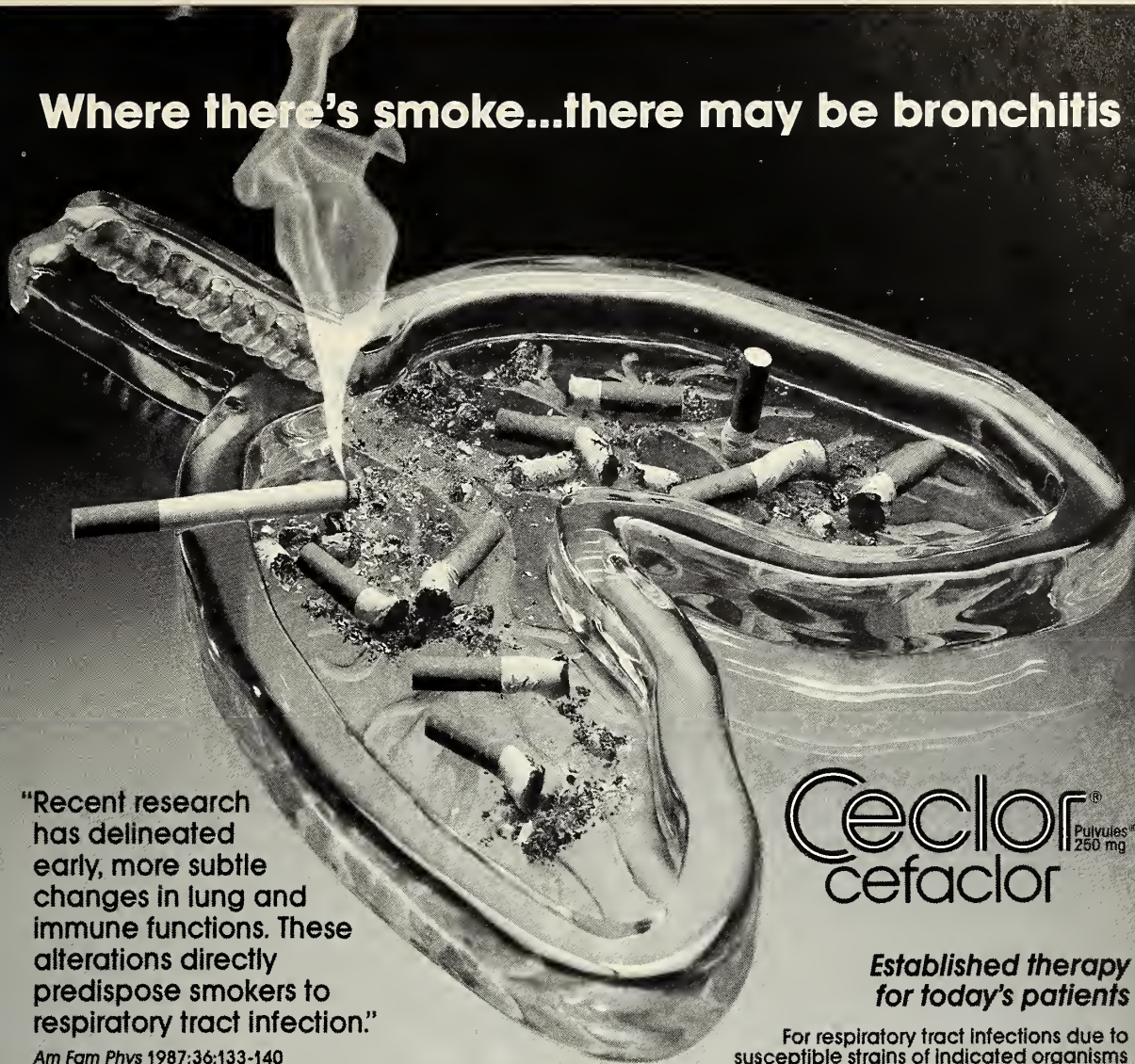
If you know of a physician who is struggling because of chemical, physical or emotional impairment, please help us to help them. Physicians' Health Committee members are all trained in this area and our results have been very good. Once physicians get treatment, either voluntary or forced, about 85% continue in recovery. **They are too proud to ask for help so we must take that initiative as caring colleagues.** We can literally "love" our colleagues to death, which is ultimately the end result of chemical dependence. If you have a troubled colleague please tell us about them. If you have questions please call us. We can and will help if you let us.

Physician Responsibility

Recognizing our responsibility to report impaired physicians, the AMA has stated, "In order to protect patients and the public, physicians have the responsibility to report to the appropriate body credible evidence of a colleague's impairment that may affect competence. Such impairment may result from abuse of drugs or alcohol, or from mental or physical illness. All physicians have an obligation to urge impaired colleagues to seek treatment." (Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association, 1989 Edition)

* Dr. Martindale is director of the Physicians' Health Care Program and chairman of the Physicians' Health Committee.

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Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of non-susceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, serum-sickness-like reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
- Stevens-Johnson syndrome, toxic epidermal necrolysis,

and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.

- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertension, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.
- Abnormalities in laboratory results of uncertain etiology.
- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
- Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Ceclor and Coumadin concomitantly.
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinistest[®] tablets but not with Tes-Tape[®] (glucose enzymatic test strip, Lilly).

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AIDS IN ARKANSAS 1990

January 1 - December 31, 1990

Total number of cases reported		207	CASES BY AGE GROUP		
Number of deaths		11	Less than 20		11
			20 - 29		55
			30 - 39		78
			40 - 49		35
			50 or more		11
CASES BY SEX					
Male		170			
Female		20			
CASES BY RACE					
White		141	OPPORTUNISTIC DISEASE		
Black		47	Pneumocystic Carinii		81
Other		2	Cryptococcosis		7
			Kaposi's Sarcoma		1
			Candida		28
			HIV Wasting Syndrome		33
			Toxoplasmosis		5
			HIV Encephalopathy		8
			Histoplasmosis		13
			Other Diseases		12
CASES BY RISK GROUP					
Homosexual/Bisexual		118			
Homosexual & IV Drug User		17			
IV Drug User		17			
Hemophiliac		5			
Transfusion		7			
Heterosexual (Contacts)		10			
NIR#		16			

No identified risk group (NIR)

AIDS IN ARKANSAS 1985 - 1990

Total number of cases reported		443	CASES BY AGE GROUP		
Number of deaths		268	Less than 20		14
			20 - 29		137
			30 - 39		194
			40 - 49		67
			50 or more		31
CASES BY SEX					
Male		402	OPPORTUNISTIC DISEASE		
Female		41	Pneumocystic Carinii		202
			Cryptococcosis		22
			Kaposi's Sarcoma		12
			Candida		56
			HIV Wasting Syndrome		50
			Toxoplasmosis		8
			HIV Encephalopathy		24
			Histoplasmosis		29
			Other Diseases		38
CASES BY RACE					
White		334	CASES BY RISK GROUP		
Black		104	Homosexual/Bisexual		282
Other		5	Homosexual & IV Drug User		45
			IV Drug User		44
			Hemophiliac		7
			Transfusion		19
			Heterosexual (Contacts)		23
			NIR#		23

No identified risk group (NIR)

Source: Arkansas Department of Health.

AIDS in Arkansas

AMS Committee on AIDS

Joseph M. Beck, M.D., Chairman

Tuberculosis and HIV

Donald Fournier, M.D.*

Recently, many articles have appeared in the medical literature concerning increased problems of tuberculosis in HIV-infected patients. These articles allude to the fact that tuberculosis presents in an atypical fashion in most AIDS patients. In fact, authorities suggest that perhaps 50% or more of AIDS cases have extra-pulmonary disease and recognition of this fact meets one of the criteria for the diagnosis of overt AIDS. Frequently, this will present as progressive adenopathy, pancytopenia, headache, and organomegaly concerning those organs involved. In pulmonary disease, upper lesions are fairly uncommon and diffuse infiltrates involving the lower lobes are seen more frequently, radiographically. Also hilar and mediastinal adenopathy are quite common. Unfortunately, undiagnosed tuberculosis in HIV-infected patients has posed a significant hazard not only to household contacts but also to health-care personnel. In a recent publication in the *Morbidity & Mortality Weekly Report*, multidrug-resistant tuberculosis was discovered in a group of health-care workers from a ward specializing in HIV-infected patients.¹ This is of obvious great concern to health-care providers, since there appears to be some delay in the diagnosis of tuberculosis in AIDS patients, for a variety of reasons.² In both of these publications, it appears that more strict adherence to established infection control practices for tuberculosis may have indeed lessened the problems.

For sake of review, *Mycobacterium tuberculosis* is an obligate parasite infecting humans. It may infect other mammalian species in close contact with humans, however humans are the only reservoir for the organism. It is a slow

growing, aerobic, non-spore-forming bacillus. Characteristically, culture growth requires approximately three to six weeks of incubation. Fortunately, a radiometric system for culturing *Mycobacterium* is now available and may yield positive results in two to six days. This requires special laboratory techniques and the culture results are dependent upon the number of organisms per specimen submitted. Organisms may be identified in a fixed smear from suspicious body fluids utilizing an acid fast stain such as the Zeihl-Neelsen stain. Many authorities suggest that 100,000 organisms per milliliter of sputum are required for a smear to be positive and that a single acid fast organism on a slide should be considered suspicious.³ This is especially true in those patients with HIV disease or overt AIDS. In fact, in the same publication, the Advisory Committee for the Elimination of Tuberculosis from the Center for Disease Control suggested that TB usually precedes or coincides with the diagnosis of AIDS. All three publications stress having a high index of suspicion in HIV patients and obtaining multiple sputum specimens for smear and culture. Again, those specimens showing positive acid fast organisms should suggest that the patient is potentially infective to those in his immediate environment and to health-care providers.

The risk of infection to persons in close contact with those HIV-infected patients with tuberculosis is directly related to the closeness of contact to that particular patient. Unfortunately, this can include health-care providers, hospital personnel, as well as friends and relatives. Most all transmitted infections from a patient with tuberculosis is through the inhalation route. Respiratory secretions are aerosolized by coughing, sneezing, or even talking. Remarkably, a cough or talking for five minutes can produce an estimated 3,000 infectious droplets of the organism. These respiratory secretions may stay suspended in air for long

* Dr. Fournier is associated with the Infection Control Committee at St. Michael Hospital in Texarkana, Arkansas.

periods of time and can even infect an unsuspecting individual without the presence of the patient themselves. Thus, those rooms utilized for aerosol treatment of AIDS patients may pose significant risks, particularly if the AIDS patient has unsuspected tuberculosis and suffers from coughing following the aerosolized treatments. In fact, this appears to have been an identified problem in the first publication.¹

The high incidence of tuberculosis infection in HIV positive patients is not unexpected, since HIV disease selectively destroys cell-mediated immunity in the host. Immune reactions to tuberculosis in normal hosts involves first macrophage processing of the tuberculosis bacillus to the lymphocytes, which normally may take several weeks. In fact, in the first few weeks of tuberculosis exposure, the host has no defense against the tuberculosis infection. Multiplication of the tuberculosis bacillus will proceed unimpeded for weeks, until there is the development of cell-mediated immunity towards the infection. This is first accomplished by macrophage processing of the tuberculosis bacillus which is then presented to unsensitized T lymphocytes. Those lymphocytes involved in this response include the CD4+ T lymphocytes, commonly referred to as helper T-cells. This presentation by the macrophages to the CD4+ T-cells requires recognition of Class II proteins of the major histocompatibility complex on the macrophage in its' presentation of the antigen to the T-cell receptor. Once this has been accomplished, the helper cell becomes activated with subsequent proliferation and production of various lymphokines. These lymphokines include several of the interleukins, gamma-interferon, chemotactic factors, macrophage activation factors, transfer factor, and tumor necrosis factor. All of these result in an intense inflammatory response to the particular antigen, in this circumstance, the tuberculosis bacillus. Generally, this response will develop in approximately six to 14 weeks after initial infection with the tuberculosis organism.

In HIV-infected patients, the response of the CD4+ T lymphocytes is impeded. This occurs for several reasons, but mostly because the human immune deficiency virus preferentially infects the CD4+ lymphocytes.⁴ Of those helper cells that have the CD4+ marker on their surface, two general populations exist. Approximately half of those CD4+ cells in circulation are "naive" cells, having not been committed to any specific antigen. These cells are capable of being stimulated by macrophages to form a mature CD4+ T lymphocyte (helper cell) which then attains a "memory" helper cell status. Approximately 40% of the CD4+ cells in circulation are naive cells that are uncommitted, while another 40% are memory helper cells. Since the AIDS virus obviously infects CD4+ T helper lymphocytes, all of these cells will be subsequently depleted in those patients with HIV disease. In fact, the virus prefers the committed memory cells over the naive cells. However, the whole population of helper cells is depleted by HIV disease, thus rendering the natural host response to tuberculosis inadequate. For this reason, patients with HIV who are infected with tuberculosis

do not mount an adequate immune response and subsequently may have a significant amount of organisms present before the illness is recognized. Also, for this same reason, a past infection with tuberculosis that has been held "in check" by appropriate cell-mediated defenses, will now become "reactivated." With progressive loss of memory T-helper cells, there is loss of recall antigen recognition, direction of B-cell antibody production, and direction to cytotoxic T lymphocyte responses. Past TB skin test positivity will then become negative, as delayed hypersensitivity responses are lost. Obviously, reactivation of old tuberculosis may become a problem, as can primary infection. In fact, this leads to the recognition of altered guidelines for tuberculosis skin testing in patients with HIV disease, since their skin test manifestations may be grossly inadequate.

All HIV-positive patients should have intradermal skin testing with five TU of purified protein derivative (PPD). For those reasons mentioned above, five millimeters of induration should be considered positive in this group, and a subsequent chest x-ray should be obtained to evaluate possible pulmonary disease.^{3,5} All patients with positive tests should have immediate sputum examination for acid fast bacteria (AFB) as well as culture and sensitivity. Empiric antituberculous therapy is clearly warranted in those cases where sputum is positive for AFB or chest x-rays are suspicious of clinical disease. In fact, given the possibility that these patients may not manifest a positive skin test because of anergy, or more likely loss of memory helper cells, one must then consider examination of suspicious body fluids for AFB early in their course. Identification of AFB or positive skin tests should be criteria for empiric treatment. Furthermore, these patients should then be identified as potentially infectious to health-care workers, hospital employees, and all close contacts. Appropriate infection control guidelines should then be initiated.

Infection control guidelines concerning tuberculosis have been well established for many years. When our awareness of tuberculosis was greatest, these guidelines were practiced on a regular basis. Because of a seemingly decreased incidence of tuberculosis in our population, many practitioners currently do not follow these same guidelines that have proved effective in infection control in the past. HIV-infected patients are frequently not placed in appropriate rooms with negative pressure, ultraviolet lights, or rooms or booths that have negative pressure relative to adjacent areas and that are exhausted directly to the outside. All of these areas should be frequently monitored for negative pressure and possible risk for contamination. If drug resistant tuberculosis is suspected, initial cultures should be tested for drug resistance.

Recommendations for the treatment of tuberculosis in AIDS patients are presented.³ These include a multiple drug regimen in those patients with active tuberculosis with AIDS. Specifically, a combination of Isoniazide 300 mgs per day, Rifampin 600 mgs per day, and Pyrazinamide 20-30 mgs/kg per day or Ethambutol 15-25 mg/kg per day should be

initiated. If there is disseminated disease or central nervous system disease or if Isoniazide resistance is present, the Pyrazinamide or the Ethambutol can be discontinued after the initial two months. The Isoniazide and Rifampin should be continued for at least six to nine months, and possibly 12 months. Those patients who merely have a positive PPD on skin testing with negative chest x-rays should receive Isoniazide 300 mgs daily and Pyridoxine 50 mgs a day for at least 12 months.

In summary, a high incidence of suspicion is necessary for HIV-infected patients for the diagnosis of tuberculosis. All HIV-positive patients should be subjected to tuberculosis skin testing, and likewise, all patients with positive tuberculosis skin tests should be considered for HIV testing. Furthermore, all HIV patients with suspected active tuberculosis should be identified early in their hospitalization and appropriate infection control guidelines should be followed to prevent unnecessary spread of infection to health-care providers, hospital employees, and close contacts of the patient. Infection control guidelines were reviewed as were guidelines for treatment of HIV-positive patients suspected of tuberculosis in health-care settings where persons with HIV infections receive care are in preparation by the Center for Disease Control and should be published in the near future in the *Morbidity & Mortality Weekly Report*.

HIV patients admitted to the hospital with any pulmonary symptoms or abnormal chest x-rays should be routinely placed in TB isolation until this illness has been excluded by appropriate diagnostic methods. This should include both skin testing and sputum examination for AFB. Proper infection control guidelines should be followed with the utilization of AFB isolation rooms with negative pressure and utilization of ultraviolet lights. Patients suspected of active tuberculosis should be on respiratory isolation and should wear masks when leaving their isolation rooms. The doors of these isolation rooms should be closed at all times and they should be tested frequently to assure negative pressure relative to the hallway. These rooms should have frequent air changes and the circulating air should be vented to the outside environment, and not into other areas of the hospital. All patients should be started on empiric antituberculous therapy at the first suspicion of active disease. Patients who may be infected with drug resistant organisms should remain in AFB isolation until their sputum smears are negative. Those patients felt to be infectious for tuberculosis should not be discharged to home where immunocompromised patients may be present or there is the potential to infect family members or relatives. Appropriate respiratory isolation should be practiced at all times. These patients also should not be transferred to institutional facilities where other immunocompromised patients are being cared for. Sputum induction and aerosolized treatments should be administered only in single patient rooms or booths that have negative pressure relative to adjacent areas and that are exhausted directly to the outside. All of these areas should be frequently monitored for negative pressure and possible risk

for contamination. If drug resistant tuberculosis is suspected, initial cultures should be tested for drug resistance.

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Next-Day Visits Following Cataract Procedures

J. David Busby, M.D., ABFP*

Each of the nation's PROs were recently surveyed for medical opinions on postoperative care of patients having cataract surgery. The survey posed questions about whether a next-day postoperative visit is felt important for patients having cataract extractions and lens procedures.

Background

Postoperative assessment within 24 hours of cataract-related procedures has been a hot topic of discussion among physicians in Arkansas and nationwide. Under the auspices of the new Federal Agency for Health Care Policy and Research the national panel charged with developing clinical guidelines for "Visual Impairments Due to Cataracts in the Aging Eye" is also addressing this issue as part of the quality and effectiveness initiatives.

According to James R. Weber, M.D., an AFMC board member who is on the five-person cataract guidelines panel, the development of practice guidelines for cataract conditions has been hampered by an outdated body of formal ophthalmologic literature. After conducting a literature search and analysis of over 8,000 articles, fewer than 200 were considered to be of research value; and, very few of these remaining articles will likely meet the test of reflecting current knowledge and practice. In short, the medical literature was found to be at least two to five years behind state-of-the-art ophthalmologic practices for cataract treatment.

Due to the dearth of up-to-date medical literature, the panel has had to resort to a more time-consuming and difficult strategy of consensus-building to develop the clinical guidelines. Next-day cataract surgery follow-up is one of the issues the panel has addressed in its consensus-building discussions, according to Dr. Weber. He pointed out the panel's acknowledgment of a recently revised white paper by the American College of Ophthalmology that does con-

tain the recommendation for next-day visits following cataract procedures. Until the panel determines current consensus and publishes its guidelines for clinical effectiveness and quality, due in 1991, Dr. Weber stressed that it would be premature to second-guess its findings.

In the midst of the controversy, Dr. Busby undertook a survey of the nation's PRO medical directors to find out how other PROs are handling allegations of substandard professional care when plans for next-day follow-up visits are not documented in surgical medical records for patients receiving cataract-related procedures such as lens extractions and replacements.

Pro Survey Results

Responses were received from thirty-two PROs representing nearly 70 percent of the states, since several responding PROs serve more than one state. The questionnaire asked whether the PRO considers it substandard quality if a patient is not seen the day following cataract surgery; whether the PRO offers any special instructions to its reviewers regarding follow-up care of cataract extraction patients; and what reasons were felt to indicate the need for such follow-up.

Ten of the thirty-two responding PROs answered "yes" — that they do consider quality of care substandard if there is not a documented plan for follow-up within 24 hours after cataract extraction. Of the nineteen PROs answering "no," six offered qualified responses acknowledging the appropriateness of some sort of follow-up:

- "Follow-up must be scheduled but it is not necessary that it be the next day."
- "Follow-up should be within 48 hours because of the possibility of infection."
- "Majority of patients in our state are seen the day following surgery."
- "Review indicates that virtually all have such follow-up."

* Dr. Busby is the medical director at the Arkansas Foundation for Medical Care, Inc., in Fort Smith, Arkansas.

- "There must be plans for follow-up evaluation."
- "We do not address this at present but we should."

Reasons given for requiring next-day follow-up exams included early detection of:

- Increased Intraocular Pressure
- Endo- or Panophthalmitis
- Hemorrhage
- Wound Dehiscence
- Corneal Abrasion

A particularly cogent response was submitted by an ophthalmologist reviewer from a PRO in one of the plains states:

"Many potential complications or problems can be recognized on the first postoperative day and often can be treated or averted by timely intervention. Commonly, there is an increase in the intraocular pressure in the first postoperative day visit and this should be urgently treated with appropriate pressure-lowering topical and/or oral medication. Many times there may be blood in the eye which would then indicate the need to limit the patient's activity, alter steroid dosage, and sometimes treat the intraocular pressure.

Signs of increased inflammation in the eye would indicate the need to initiate a higher than usual level of steroid treatment. Suture placement problems, wound dehiscence, or leakage of the wound should be recognized and treated as early as possible. Problems with a shallow anterior chamber

and choroidal detachment can also be recognized on the first post-operative day and dealt with in an appropriate fashion. Although infection may take four to five days to manifest, it is essential to evaluate the inflammatory response on the first day postop to be able to judge that the inflammatory response is indeed increasing on subsequent postop visits. Intraocular infection, although often devastating to the eye, may have a very subtle and insidious onset. The first postoperative examination by the operating surgeon is an essential part of quality surgical care of the patient."

Conclusion

The AFMC's position is that the potential benefits of routine next-day postoperative examinations of patients following cataract extractions and lens insertion procedures far outweigh the risk of losing the precious gift of sight — especially when such loss can be so easily prevented. While there is only a small possibility of a problem developing within 24 hours after cataract-related procedures, early recognition and treatment of potentially sight-threatening complications would seem to justify the next-day postop visit.

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"Parameters" in the Emergency Room

J. Kelley Avery, M.D.*

On September 7th, a 54-year-old male was brought to the Emergency Room by Ambulance following an automobile accident. The time was 11:20 PM. The examination by the ER physician revealed the odor of alcohol on the patient's breath. There was a small laceration on the left side of the face. There was the loss of three teeth, but no reported loss of consciousness. There were some abrasions and contusions on the chest and it was apparent that the patient's face and chest had struck the steering wheel.

Further examination revealed: BP 108/70 and P 94. Heart: Rate and rhythm normal. No murmurs were heard. Chest: No tenderness to percussion. Abdomen: No muscle guarding of rebound. No organomegaly.

Treatment: 1) Suture of the laceration face.
2) Head and Wound sheet given.
3) Return 5 days.

The patient died at home about 36 hours after his ER treatment.

An autopsy was done which revealed the following significant findings: 1) blunt trauma chest and abdomen, 2) multiple fractures ribs, left chest, 3) transection of the duodenum with marked pneumoperitoneum and free gastric contents (800 cc) with fulminant peritonitis.

Cause of death was listed as Septic shock secondary to fulminant peritonitis.

On the day of the patient's death the physician's office record showed, "While in hospital ER, I asked the driver what caused the accident. He said he didn't know. The driver was treated and released the AM of 9/8. (day before death)

The details of the accident were recorded in the patrolman's report. This report indicated that the car skidded 42 feet and was airborne for about 100 feet before coming to rest

on a hill side. It was not clear from the record whether the physician was aware of the details of the accident or not.

A lawsuit was filed demanding two million dollars and charging wrongful death. Settlement was reached for a large amount.

Loss Prevention Comments

Whatever the reason, the physician who saw the patient in the ER did not take into account the details of the accident itself. He mentioned in his office record his questioning of the patient about the cause and apparently left the subject with the patient's answer that he, the patient, did not know. This clearly points to at least two possible conclusions: 1) although there was no history of unconsciousness given by the patient, there might well have been some amnesia for the events by the patient, there might well have been some amnesia for the events of the accident itself; or 2) the physician did not inquire of anyone who knew about the details.

When confronted with the victim of a MVA in the ER, the physician must take into account details about the wreck that are known or suspected by those who observed the scene, i.e., the EMS Technicians, the Law Enforcement Officers, witnesses, etc. Skid marks, seat belt restraints, air bags, roll overs, airborne, and the like are vital to the assessment of the possible injuries to the victim. The odor of alcohol on the breath is another important consideration. How much alcohol? The usual "couple 'a beers" or a liter of whiskey? Again, witnesses or those who accompany the victim may have vital information.

The autopsy findings indicating the extent of blunt trauma to the upper abdomen certainly suggest that the patient's ER assessment and treatment might have been below an acceptable standard. Transection of the duodenum is not an uncommon finding in victims of MVA's who have undergone sudden deceleration causing the driver to be thrown against the steering column with such force that the portion of the duodenum fixed against the spine is divided. What was recorded about the accident suggested that the

* Dr. Avery is the chairman of the Loss Prevention Committee of State Volunteer Mutual Insurance Company and medical director of Ambulatory Services at Saint Thomas Hospital in Nashville, Tennessee.

damage to the face and the contusions and laceration of the chest wall had been produced by contact with the steering wheel. "Multiple rib fractures, left chest", when viewed against the physical examination in the ER, "Chest--No tenderness to percussion", suggest inadequate evaluation or a patient unable to respond appropriately because of ETOH anesthesia, concussion or some other reason related to the accident.

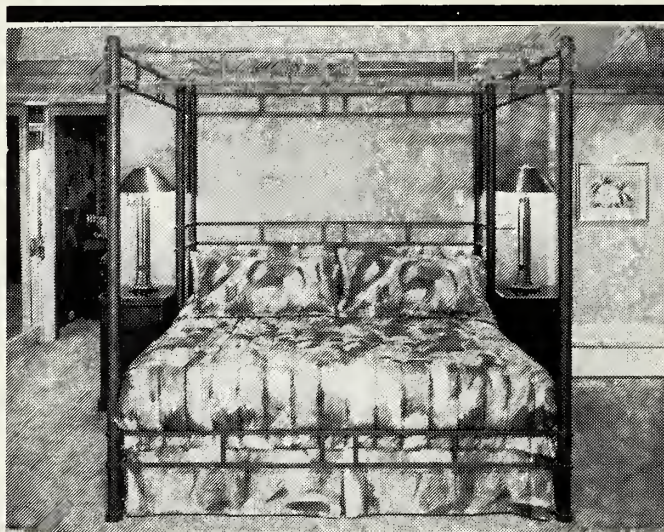
In recent years there has been an evolution in the management of trauma throughout the country. The Trauma Center development which has seen the hospital Emergency Rooms designated and licensed as Level I, II, or III Trauma Centers has established, if you will, a "standard of care" for the evaluation and management of patients who are victims of trauma. The EMS Technicians all across the state are under guidelines as to where to transport these patients based on the site evaluation of the extent of injury. The most seriously injured are transported initially to the Level I centers unless they require stabilization in another facility before transport is deemed to be in the patient's best interest.

This would certainly imply that such a clinical judgement could be made by a physician in an ER with a designation other than Level I, or no designation as a Trauma Center.

This Trauma Center movement was developed from the experience of trauma surgeons through the impetus of the American of Surgeons. It could be called one of the earliest developments of "parameters" of appropriate care about which we will be hearing more and more as various Specialty Societies, the AMA, and even the physician-owned medical malpractice insurance carriers become involved. Whether we like it or not, this is the reality with which we as practicing physicians are faced.

In this case, is it proper to infer that this patient, probably a victim of his own excesses, would not have died if he had been initially transported to a Level I Trauma Center? Certainly not!! But, judged against the current standards (PARAMETERS) which are in great measure the result of the TRAUMA CENTER development, the inference of a deviation from an acceptable standard of care was so strong that this case had to be settled before trial.

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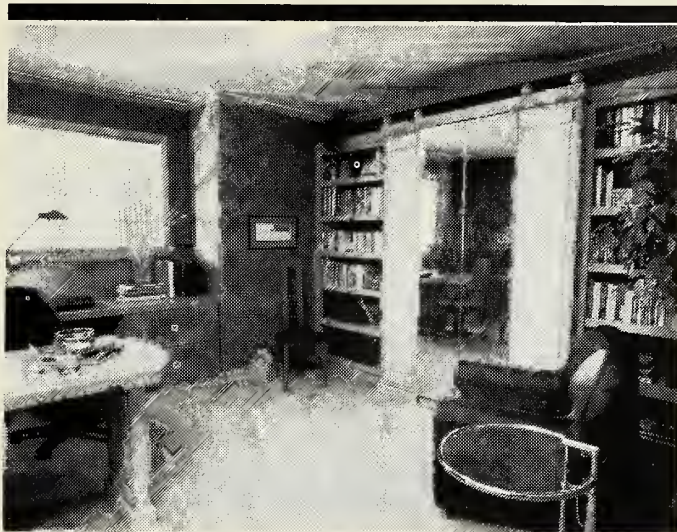
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AMS Newsmakers

The **Boone County Medical Society** has awarded a scholarship in the amount of \$500 to the North Arkansas Community College in the name of **Ross Fowler, M.D.**

The scholarship is to be awarded to a nursing student who exhibits high scholastic aptitude and sincere devotion to the nursing profession.

David C. Jacks, M.D., a Pine Bluff urologist, has been elected to the Executive Committee of the Southern Medical Association (SMA).

The **Ouachita County Medical Society** recently announced its officers for 1991. They are: **R.H. Nunnally, M.D.**, president and alternate delegate; **Val Shrestha, M.D.**, vice president; **Jerry Kendall, M.D.**, secretary-treasurer; **Bill Dedman, M.D.**, delegate; **Cal R. Sanders, M.D.**, program chairman.

The **Pulaski County Medical Society** recently announced its officers for 1991. They are: **Ashley S. Ross, M.D.**, president; **R. Jerry Mann, M.D.**, president-elect; **D. B. Allen, M.D.**, vice president; **Joseph M. Beck, M.D.**, secretary; **Robert G. Valentine Jr., M.D.**, treasurer; and **Charles P. Fitzgerald, M.D.**, treasurer-elect.

William Scurlock, M.D., of El Dorado, has been elected to the American Cancer Society, Arkansas Division, Board of Directors.

The laboratory at **Sparks Regional Medical Center** has been awarded a two-year accreditation by the commission on Laboratory Accreditation of the College of American Pathologists (CAP), based on results of a recent on-site inspection.

Eugene Towbin, M.D., the chief of staff at John L. McClellan Memorial Veterans Hospital in Little Rock, was presented the Robert Shields Abernathy Award for Excellence in Internal Medicine by the Arkansas Chapter of the American College of Physicians. The award recognizes an internist who has trained, practiced or taught in Arkansas and achieved distinction in the profession.

The Arkansas affiliate of the American Diabetes Association has donated \$13,115 for diabetic retinopathy research at the **University of Arkansas for Medical Sciences**.

Keeping Up ---

Evaluation of Murmurs in Children

February 20, 12:00 noon. Sponsored by AHEC-Fort Smith and presented by J.B. Norton, M.D. in the seventh floor dining room at Sparks Regional Medical Center.

Annual Cardiovascular Update

February 22. Presented by the Baptist Medical Center in the J.A. Gilbreath Conference Center. For more information, call BMC Medical Education at 227-2672.

Magnetic Resonance Imaging: Theory and Applications

February 28-March 1. Sponsored by the UAMS College of Medicine and presented by Edgardo Angtuaco, M.D. in the UALR Engineering Building, Room 553. Category I credit offered. Fees: \$195.00. For more information, call Kathy Meyer at 686-5261.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

CME Luncheon, second and fourth Friday, 12:30 p.m. AMI Ozark-Quapaw Room. One Category I credit per meeting.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), third Wednesday, 12:30 p.m., Conference Room, Building 1, VAMC
Medical Grand Rounds, Fridays, 12:00 noon, VAMC

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Faculty Resident Seminar, third Thursday, 12:00 noon, Sturgis Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Building, Room 457
Infectious Disease Conference, second Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Building, Auditorium
Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., 2nd Floor Classroom
Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, 2nd Classroom
Pediatric Research Conference, first Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

Sleep Disorders Case Conference, second and fourth Thursday. Video production conference room. Lunch provided.
Interdisciplinary AIDS Conference, second Friday, 12:00 noon. LaHarpe Room. Sandwich buffet is served.
Cancer Conference, third Thursday, 12:00 noon, Laboratory Conference Room. Lunch is provided.
Hematology-Oncology Conference, second Thursday, 12:00 noon. Lunch is provided.
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Southwestern Bell/Arkla Room. Refreshments are provided.
Pulmonary Conference, second and fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla Room. Sandwich buffet is served.
Journal Club, every Tuesday, 12:00 noon, Lunch is provided.
GYN Surgery Cancer Conference, second Monday, 12:00 noon. Lunch is provided.
Joint Tumor Conference, first Wednesday, 12:00 noon. CARTI Auditorium. Lunch is provided.

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., Conference Room 1
GI Conference, fourth Friday, 12:00 noon. Lunch is provided.
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lectures and case presentations. A light lunch is provided.
Pathology Conference, first Tuesday, 3:00 p.m., Pathology Library
Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource Room, 2nd floor/BMC. Lunch is provided.
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch is provided.
Sleep Case Conference, Fridays, 12:00 noon. Lunch is provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC Oncology Forum, fourth Thursday, 4:00 p.m., UAMS ACRC 2nd Floor Conference Room, 1.5 credits
Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
Anesthesia Morbidity and Mortality Conference, second and fourth Tuesdays, 6:45 a.m.; first, third and fifth Thursdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy
Cardiothoracic Surgery Conference, first Thursday, 8:00 a.m., location varies
Child Psychiatry Clinical Case Conference/Research Review, most Fridays, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room
Dermatopathology Conference, Tuesdays, 8:00 a.m., UAMS Education Building, Room G/108 A&B
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Building, Room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Building, Room G/110A&B
Emergency Medicine Grand Rounds 1, third Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Grand Rounds 2, third Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology Conference Room, #M1/293.
Hematology Fellow's Forum, second, third, and fourth Fridays, 8:15 a.m., ACRC Betsy Blass Conference Room
Hematology/Oncology Clinical Problems Conference, Thursdays, 8:15 a.m., LRVA Pathology Conference Room
Interdisciplinary Gynecologic Cancer Conference, Fridays, 12:30 p.m., UAMS Education Building, Room G106 A&B
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., St. Vincent Infirmary Education Bldg., Arkla/Bell Room
LR Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC Conference Room thrice a month, CARTI Auditorium once a month
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Building, Rom G/131A&B
Medicine Research Conference, three Wednesdays per month, 4:30 p.m. Shorey Building, Room 3S06
Neurology Clinical Case Conference, Thursdays, 8:00 a.m. VAMC-LR Room 2D109
Neuropathology Conference, Thursdays, 10:00 p.m. UAMS Morgue
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Ob/Gyn Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Building, Room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, Room 3/150, 2 credit hours
Orthopaedic Basic Science Conference, occasional Tuesdays, 11:00 a.m., UAMS Education Bldg., Room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Building, Room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Building, Room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Building, Room B/135
Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Shorey Auditorium
Surgery Basic Sciences Conference, first Saturday, 7:30 a.m., ACRC 2nd floor conference room
Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room
Surgery Morbidity and Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room
Surgery Resident Case Conference, second, third, fourth, fifth Saturday, 7:30 a.m., ACRC 2nd floor conference room
Surgery Staff/Clinical Case Conference, alternating Tuesdays, 7:00 a.m., UAMS Education Building, Room G/141
Surgery Vascular/Radiology Conference, Tuesdays, 5:00 p.m., VAMC-LR Radiology Conference Room
Surgery Vascular Teaching Conference, Thursdays, 3:00 p.m., VAMC-LR Radiology Conference Room.
Urology Basic Sciences Conference, second Wednesday, 5:00 p.m., UAMS Education Building, Room G/106A&B
Urology Clinical Didactic Conference, third Tuesday, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
Urology Core Conference, once or twice monthly, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
Urology Grand Rounds, second and fourth Tuesday, 5:00 p.m., VAMC-LR (4D)
Urology Morbidity and Mortality Conference, last Wednesday, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
Urology Teaching Conference, once or twice monthly, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
Uro-Radiology Conference (Urologic Imaging), once monthly, 5:00 p.m., UAMS Shorey Bldg., Room 2S08
VA Chest Conference (combined Surgical/Medical Chest Conference), alternating Mondays, 12:15 p.m., VAMC-LR, Room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine Conference Room, Room 1D173
VA Geriatric/Gerontology Research Conference, Wednesdays, 3:15 p.m., VAMC-LR, Room 1E123
VA Hematopathology Conference, Wednesdays, 3:00 p.m., VAMC-LR Pathology Conference Room
VA Lung Cancer Conference (combined Medical/Surgical Lung Cancer Conference), Tuesdays, 3:00 p.m., VAMC-LR, Room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Building 68
VA Medicine-Pathology Conference, Tuesday, 2:00 p.m., VAMC-LR, Room 2D109
VA Medicine Service Resident's Clinical Case Conference, Fridays, 12:00 noon, VAMC-LR, Room 2A109
VA Physical Medicine and Rehab Grand Rounds, fourth Friday, 11:00 a.m., VAMC-NLR Building 68, Room 118 or Arkansas Rehab Institute

VA Psychological Assessment Conference, Tuesdays, 3:00 p.m., VAMC-LR & NLR Psychology Department, 1.5 credit hours
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, Room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine Conference, Thursdays, 8:00 a.m., VAMC-NLR Building 68, Room 118
VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology Conference Room

EL DORADO - AHEC

Behavioral Sciences Conference, first and fourth Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, second Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second and fourth Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, fourth Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, first, second and third Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

Behavioral Sciences Conference, third Wednesday, 12:00 noon, Washington Regional Medical Center
City Hospital Staff Medical Meeting, second Friday, 12:00 noon, Fayetteville City Hospital
Family Medicine Conference, first, third, fourth Thursday; fourth Wednesday; second Thursday (odd months) AHEC-NW, 241 W. Spring, Fayetteville
Interesting Case Conference, 1st and 3rd Friday, 12:00 noon, Fayetteville City Hospital
Medicine Conference, first and third Tuesday, 12:00 noon, Washington Regional Medical Center
OB/GYN Conference, February 14, 12:00 noon, AHEC Conference Room
Pediatric Conference, second Wednesday, 12:00 noon, Washington Regional Medical Center
Radiology Conferenc, February 6, 12:00 noon, Washington Regional Medical Center
Nutrition Conference, January 2, 12:00 noon, Washington Regional Medical Center
Surgery Conference, second Tuesday, 12:00 noon, Washington Regional Medical Center Fulbright Board Room

FORT SMITH - AHEC

Internal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center
Neuroradiology Conference, third Wednesday, 12:00 noon, St. Edward Mercy Medical Center
Pediatric Cardiology, November 21, 12:00 noon, Sparks Regional Medical Center, 7th floor dining room
Issues in Ventilator Weaning, November 28, 12:00 noon, Sparks Regional Medical Center, 7th floor dining room

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first and third Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.
Chest Conference, second Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided
Craighead/Poinsett Medical Society, first Tuesday, 7:00 p.m. Jonesboro Country Club
Eaker AFB CME Conference, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria
Independence County Medical Society, second Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, fourth and fifth Tuesday, 12:00 noon, St. Bernards Dietary Conference Room. Lunch provided.
Jackson County Medical Society, third Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, third Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, second Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neuroradiology Conference, third Friday, 12:00 noon, St. Bernards Dietary Conference Room. Lunch provided.
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Pocahontas CME Conference, third Wednesday, 12:00 noon and 7:30 p.m., Randolph County Medical Center Boardroom
Tumor Conference, 2nd Thursday, 4th Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided
Walnut Ridge CME Conference, third and last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

PINE BLUFF-AHEC

Behavioral Science Conference, first and third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second and fourth Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, first and fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, second and fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second and fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.

Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

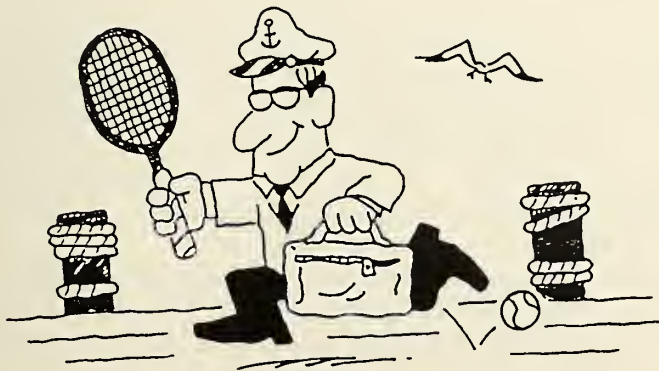
TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Neuro-Radiology Conference, first and third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

Make Plans For Shore Leave!

Relax and play golf or tennis with your colleagues, spouses and exhibitors prior to the Council Meeting and/or House of Delegates on Thursday, April 25, 1991. The fun will begin at 10:00 a.m.

Information on rules, tee and court times will be announced at a later date. The golf fee will be \$35.00 per person, and the tennis fee will be \$20.00 per person.



***Arkansas Medical Society
1991 Annual Session
Arlington Hotel
Hot Springs, Arkansas
April 25 -27, 1991***

Things To Come

February 21-24

Rhinoplasty. Location and fees to be announced. Sponsored by the Washington University School of Medicine, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862.

February 28-March 2

Advances in Pulmonary and Critical Care Medicine. Round Hill Resort, Montego Bay, Jamaica. Sponsored by the Southern Medical Association. CME Category I credit available. For more information, call LaDonna Nail at 1-800-423-4992.

February 28-March 2

Innovations in Radiological Techniques and Technologies. The Princess Hotel, Acapulco, Mexico. Sponsored by the Southern Medical Association. CME Category I credit available. For more information, call LaDonna Nail at 1-800-423-4992.

March 2-7

ASCP/CAP 1991 Spring Meeting. Opryland Hotel, Nashville, TN. Sponsored by the American Society of Clinical Pathologists, in conjunction with the College of American Pathologists. For more information, call 1-800-621-4142.

March 15-17

Office Management of Infectious Diseases. Sandestin Beach Hilton, Destin, FL. Sponsored by the Southern Medical Association. CME Category I credits available. For more information, call LaDonna Nail at 1-800-423-4992.

April 10-13

Treatment of Surgical Spine Disease, The Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Washington University School of Medicine. For more information, call Cathy Caruso at 1-800-325-9862.

April 17-21

5th Annual Critical Care Update, The Crowne Plaza Hotel, Rockville, MD. Sponsored by the Society of Critical Care Medicine and Rush-Presbyterian-St. Luke's Medical Center. Fees: \$695.00, physicians; \$525, physicians in training and allied health professionals. Category I credits available. For more information, call (201) 385-8080.

April 19-21

Focus on the Athletic Patient. The Cottages, Hilton Head, SC. Sponsored by the Southern Medical Association. CME Category I credits available. For more information, call LaDonna Nail at 1-800-423-4992.

April 19-21

Advances in Surgical Techniques and Technologies. The Homestead, Hot Springs, VA. Sponsored by the Southern Medical Association. CME Category I credits available. For more information, call LaDonna Nail at 1-800-423-4992.

April 21-23

8th National Conference on Prescription Medicine Information and Education. Omni Shoreham Hotel, Washington DC. Sponsored by the National Council on Patient Information and Education. For more information, call (202) 347-6711.

April 26-28

Diagnostic Dilemmas in Cardiology. Kingston Plantation, Myrtle Beach, SC. Sponsored by the Southern Medical Association. CME Category I credits available. For more information, call LaDonna Nail at 1-800-423-4992.

April 30-May 2

Molecular Basis of Bone Cell Physiology: Transcellular Signaling, The Sheraton West Port Inn, St. Louis, MO. Sponsored by the Washington University School of Medicine. For more information, call Cathy Caruso at 1-800-325-9862.

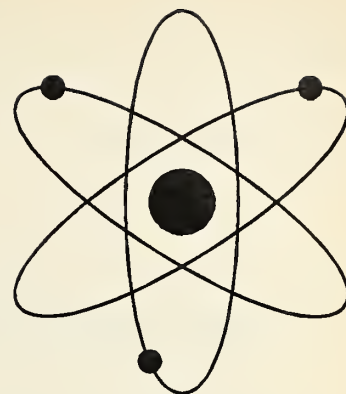
May 1-3

Protection for Research Risk, The Hyatt Regency, Union Station, St. Louis, MO. Sponsored by the Washington University School of Medicine. For more information, call Cathy Caruso at 1-800-325-9862.

May 3-5

Diagnostic Dilemmas in Neurology and Psychiatry. The Grand Hotel, Point Clear, AL. Sponsored by the Southern Medical Association. CME Category I credits available. For more information, call LaDonna Nail at 1-800-423-4992.

Radiological Case of the Month



Keith Dixon, M.D.
David L. Harshfield, M.D.
Steve Nokes, M.D.



Fig. 1. PA chest view.

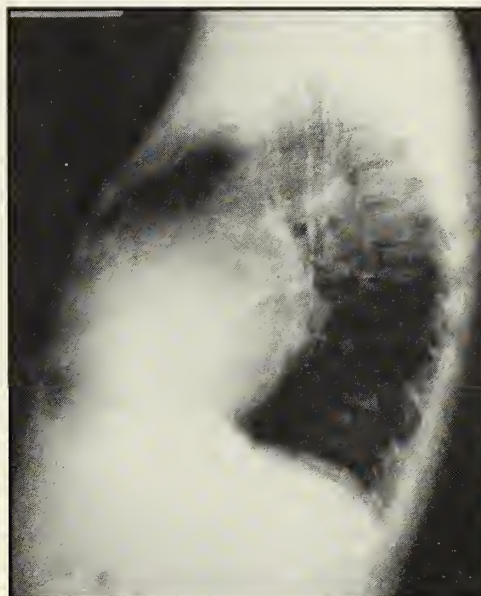


Fig. 2. Lateral chest view.

Clinical History:

This is a 20 year-old black male who presented with shortness of breath.

Renal Osteodystrophy

Radiographic Findings:

The PA and lateral chest film was available for review and demonstrates marked cardiomegaly with no significant pulmonary vascular redistribution or evidence of congestive failure. There are numerous skeletal findings in addition to the increased heart size. There is a generalized undermineralization of the bones. There is a definite absence of the cortex to the bones of the thorax. Note particularly the clavicles. On the lateral view, there is increased density in the region of the superior and inferior vertebral end-plates producing a Rugger-jersey spine.

Conclusion:

Increased size of the cardiac silhouette in the absence of signs of congestive failure, such as pulmonary vascular redistribution, blunting of the costophrenic sulci (indicating pleural effusion), and interstitial prominence or alveolar edema make cardiomegaly suspect as the sole cause of this radiographic finding. Instead, in the absence of other findings of congestive failure, one should suspect pericardial effusion in this instance. One of the earliest findings of pericardial effusion will be straightening of the left heart border as the fluid accumulates in the pericardial space at the junction of the aortic knob, pulmonary artery shadow, and the beginning of the left ventricular contribution to the cardiac silhouette. The presence of pericardial effusion accompanied by the skeletal findings as described above points to renal osteodystrophy as an etiology for this patient's findings. In fact, this young black male had end-stage renal disease and had developed pericardial effusion. This disease has been called renal rickets in the past, however, now most investigators believe that the term renal osteodystrophy is preferable since most of the skeletal disease which develops is caused by increased parathyroid activity (secondary hyperparathyroidism). Recent investigations indicate that the pathogenesis is related to the intestinally active metabolite of Vitamin D which is generated in kidney tissue. As a result of certain renal diseases, a decrease in this substance would inhibit the removal of calcium from the intestine causing hypocalcemia. This would in turn stimulate the parathyroids and lead to the clinical state of hyperparathyroidism. The low serum calcium level causes failure of normal mineralization of newly formed bone and thus the changes of both rickets and hyperparathyroidism develop. Renal osteodystrophy also occurs following renal transplantation. In addition to the signs of secondary hyperparathyroidism, a number of other skeletal changes have been demonstrated in patients who have had renal transplant. Ischemic necrosis of the femoral head occurs in nearly one half of those with skeletal changes. Although not present in this patient, other radiographic findings include subperiosteal resorption, classically described as loss of cortex of the lateral aspect of the middle phalangeal shaft of the fingers.

Editor: Steven R. Nokes, M.D., is in private practice and is affiliated with Radiology Consultants in Little Rock.

Editor: David Harshfield, M.D., chief of the radiology service at the Veterans Administration Hospital in Little Rock, and head of radiology at Riverside Radiologist Group in North Little Rock.

Keith Dixon, M.D., medical director of Central Arkansas Dialysis and Transplantation, P.A.

New Members

BAXTER COUNTY

Barker, Monty R., Otolaryngology, Mountain Home. Born May 6, 1957, Wichita, KS. Medical education, University of Kansas, Kansas City, 1985. Internship, Wesley Medical Center, Wichita, KS, 1986. Residency, Kansas University Medical Center, 1990. Board eligible.

Kilgore, Kenneth M., Ophthalmology, Mountain Home. Born March 16, 1960, Kansas City, MO. Medical education, UAMS, 1986. Internship, UAMS, 1987. Residency, University of South Florida, Tampa, 1990. Board eligible.

CRAIGHEAD COUNTY

Tidwell Jr., Kenneth K., Diagnostic Radiology, Jonesboro. Born April 6, 1959, Oklahoma City, City. Medical education, Oklahoma University Medical School, Oklahoma City, 1985. Residency/Internship, Oklahoma University Teaching Hospitals, 1989. Board certified.

JEFFERSON COUNTY

Croswell, Kent L., Family Practice, Pine Bluff. Born December 3, 1957, Little Rock. Medical education, Texas Tech University, Lubbock, 1987. Internship, UAMS, 1988. Residency, AHEC-Pine Bluff, 1990. Board certified.

SEBASTIAN COUNTY

Everett, Karen A., Adult Neurology, Fort Smith. Born March 13, 1956, Pasadena, CA. Medical education, University of New Mexico, Albuquerque, 1981. Internship, Good Samaritan/Phoenix VA, 1986. Residency, UAMS, 1990. Pending certification.

WASHINGTON COUNTY

Grote, Walton W., Anesthesiology, Fayetteville. Born January 30, 1950, Corpus Christi, TX. Medical education, University of Texas Medical Branch, Galveston, 1975. Internship/residency, University of Texas Health Sciences Center, San Antonio, 1978. Practice experience, 12 years. Board eligible.

Pope, Kevin L., Diagnostic Radiology, Fayetteville. Born January 24, 1958, Pasadena, TX. Medical education, University of Missouri, Kansas City, 1985. Residency, University of Texas Medical Branch, Galveston, 1990. Board certified.

Raben, C.A. (Tony), Orthopedic Surgery, Fayetteville. Born May 2, 1953, Clayton, MO. Medical education, University of Kansas Medical School, Kansas City, 1984. Internship/residency, Hamot Medical Center, Erie, PA, 1989. Practice experience, 1 year. Board eligible.

RESIDENT

Albers, James H., PM & R. Born January 13, 1962, San Antonio, TX. Medical education, University of Texas Medical Branch, Galveston, 1988. Internship/residency, UAMS.

Brown, Dennis R., Internal Medicine. Born June 6, 1962, Searcy. Medical education, UAMS, 1988. Residency, UAMS.

Bryan IV, James W., Family Medicine. Born October 10, 1963, Paso Robles, CA. Medical education, UAMS, 1990. Internship, UAMS.

Carney, Susan H., Ophthalmology. Born December 7, 1960, Kansas City, MO. Medical education & internship, University of Missouri, Kansas City. Residency, UAMS.

Claycomb, Scott C., Ophthalmology. Born February 21, 1964, Little Rock. Medical education, UAMS, 1990. Internship/residency, UAMS.

DeValle, Oscar L., Family Practice. Born July 26, 1957, Havana, Cuba. Medical education, Spartan Health Sciences University, St. Lucia, WI, 1987.

Gober, Gregg A., Orthopedics. Born January 16, 1963, Monroe, LA. Medical education, UAMS, 1989. Internship, Georgetown University, Washington, D.C. Residency, UAMS.

Govindan, Mohan, Cardiology. Born December 22, 1949, India. Medical education, Maulana Azad Medical College, New Delhi, India, 1973. Internship/residency, St. Mary's Hospital, Rochester, NY, 1990.

Hah, Wilbur, Otolaryngology. Born April 20, 1964, Hong Kong. Medical education, University of Texas Medical School, San Antonio, 1990. Internship/residency, UAMS.

Haut, Paul R., Pediatrics. Born March 13, 1963, Salt Lake City, UT. Medical school, UAMS, 1990. Residency, UAMS & Arkansas Children's Hospital.

Hearnberger, John E., Cardiothoracic Surgery. Born January 23, 1947, Little Rock. Medical education, UAMS, 1973. Board certified.

Holcomb, Timothy E., Internal Medicine. Born June 6, 1951, Little Rock. Medical education, UAMS, 1988. Internship/residency, UAMS.

Hurlburt, Kimberly N., Pediatrics. Born April 27, 1964, Edna, TX. Medical education, University of Houston, TX, 1990.

Hutchison, George R., Emergency Medicine/Internal Medicine. Born July 17, 1953, Dallas, TX. Medical education, Southwestern Medical School, Dallas, TX, 1986. Internship/residency, UAMS.

Kleinschmidt, James C., Surgery. Born February 6, 1960. Medical education, UAMS, 1986. Residency, UAMS.

Lintecum, Neal D. Born November 3, 1962, Kansas City, MO. Medical education, University of Kansas, Kansas City, 1990. Internship, UAMS.

Little, James A., General Surgery. Born June 29, 1963, Little Rock. Medical education, UAMS, 1990. Residency, UAMS.

Massey, Samuel O., Radiology. Born June 19, 1963, Picayune, MS. Medical education, University of Mississippi School of Medicine, Jackson, 1989. Internship, University of Mississippi School of Medicine, Jackson. Residency, UAMS.

Mitchell, Alan L., Radiology. Born March 3, 1964, Monroe, LA. Medical education, Louisiana State University Medical Center, Shreveport, 1990. Internship, UAMS.

Neal, Linda A., Psychiatry. Born November 18, 1953, Poplar Bluff, MO. Medical education, UAMS, 1988. Internship/residency, UAMS.

Neaville, Greg W., Internal Medicine. Born January 2, 1964, Memphis, TN. Medical education, UAMS, 1990. Internship/residency, UAMS.

Nguyen, Duong H., Psychiatry. Born October 24, 1962, Saigon, Vietnam. Medical education, UAMS, 1988. Internship/residency, UAMS.

Ohlhausen, Deborah B., Internal Medicine. Born July 15, 1961, Ft. Dodge, IA. Medical education, University of Missouri, Columbia, 1988. Internship/residency, UAMS.

Page, Suzanne E., PM&R. Born September 14, 1958, Dayton, OH. Medical education, University of Texas, San Antonio, 1983. Residency, UAMS.

Roppolo, Michael W., Internal Medicine. Born May 19, 1964, Shreveport, LA. Medical education, Louisiana State University School of Medicine, Shreveport, 1988. Internship/residency, UAMS.

Schonefeld, Pamela J. Born October 11, 1965, Alexandria, LA. Medical education, LSU Medical School, New Orleans, 1990. Internship, UAMS.

Sowell, John K., Dermatology. Born June 24, 1965, Huntsville, AL. Medical education, University of Alabama, Birmingham, 1990. Internship/residency, UAMS.

Stroope, Judith L., Internal Medicine. Born July 13, 1957, Little Rock. Medical education, UAMS, 1989. Internship/residency, UAMS.

Ureckis, David. Born February 12, 1962, Detroit, MI. Medical education, UAMS, 1990. Internship, AHEC-Northwest.

Urrutibeheity, Gisele, Psychiatry. Born September 23, 1962, Argentine. Medical education, University of Texas at Houston, 1990. Internship/residency, UAMS.

Walha, Santorh S., Neurology. Born March 16, 1959, Jhansi, India. Medical education, Payanand Medical College, Ludhiana, Punjab, India, 1983. Internship, Prince Georges Hospital Center, Cheverly, MD. Residency, UAMS.

Ziller III, Stephen A., Gastroenterology. Born July 16, 1962, St. Louis, MO. Medical education, University of Cincinnati, OH, 1988. Internship/residency, UAMS.

Arkansas Medical Society 1991 Annual Session Arlington Hotel

*See You in Hot Springs!
April 25-27, 1991*



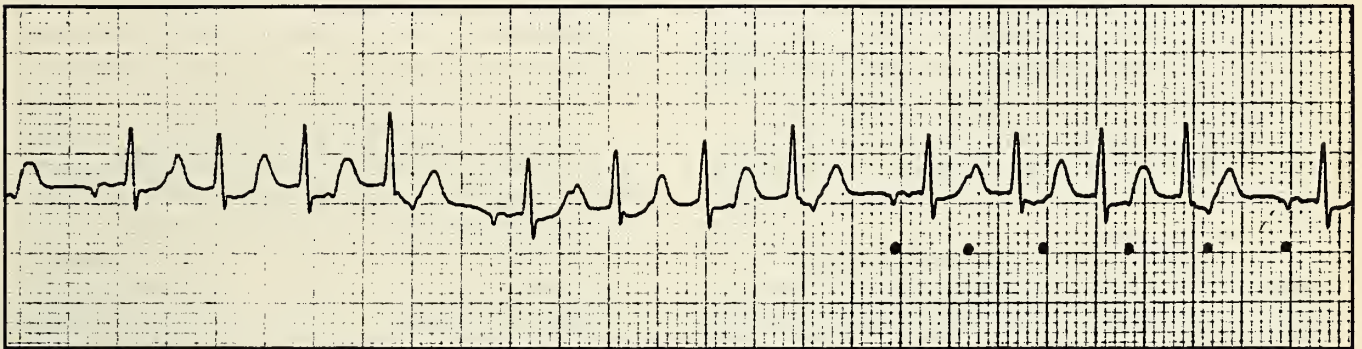


Electrocardiogram of the Month

Jon P. Lindemann, M.D.
UAMS Division of Cardiology
Little Rock, Arkansas

CLINICAL HISTORY:

This record was obtained from a 55 year-old female who presented with a complaint of palpitations and feeling ill. She was on no chronic medications. What is the rhythm in this lead II rhythm strip?



DISCUSSION:

This record demonstrates paroxysmal junctional tachycardia with anterograde Type I (Wenckebach) block and a constant retrograde 1:1 retrograde conduction. Another recording obtained 45 minutes later was normal, indicating the paroxysmal nature of the dysrhythmia.

The record shows a regularly irregular tachycardia with "group beating." The inverted P waves (indicated by dots) occur at a regular interval of 0.32 seconds (rate = 188) suggesting either a low atrial or AV junctional mechanism with 1:1 retrograde conduction controlling the atria. Second degree AV block is present with a conduction ratio of 5:4. Several features suggest that the second degree block is Type I (Wenckebach). First, the R-R interval surrounding the pause is less than the sum of the two preceding R-R intervals; second, the R-R interval following the pause is longer than the R-R interval preceding the pause; and third, the conducted R-R intervals gradually shorten. Careful inspection of the record also demonstrates gradual prolongation of the manifest P-R intervals. In the presence of long Wenckebach cycles such as this, R-R shortening and P-R prolongation may be minimal, resulting in the appearance of equal R-R cycles preceding the pause.

This record illustrates several important points. Although "supraventricular tachycardia with AV block" is a common manifestation of digitalis excess, it can occur in the absence of digitalis as is the case in the present record. Additionally, Wenckebach type block is commonly thought of only in the presence of gradual prolongation of the P-R interval. However, as is illustrated in this record, Wenckebach block can just as easily be recognized by the effects observed on complexes or conduction distal to the level of block (in this case, the R-R intervals). Indeed, Wenckebach block has been observed in nearly all regions of the heart and only in the case of the AV node will such block result in prolongation of the P-R interval.

Medicine in the News

President Bush Proclaims "National Doctors' Day"

President George Bush recently signed a proclamation establishing March 30th as "National Doctors' Day." This culminates the efforts of legislators who passed both Senates and House Resolutions to establish a day in recognition of the invaluable contributions physicians have made to the Nation and continue to make daily.

Approximately 586,000 physicians in 37 specialties practice medicine in the United States today, each playing an important role in meeting America's medical needs. From the rural doctor to the most highly trained specialist, physicians touch the lives of almost every person in the community.

Doctors' Day was first observed regionally on March 30, 1935, when it was begun by the Auxiliary of the Southern Medical Association. Since then, it has been observed yearly in most states to show appreciation for the role of physicians in caring for the sick, advancing medical knowledge, and promoting improved public health. Over the years, mayors of small towns and large cities have proclaimed this day to be set aside in recognition.

Today, Doctors' Day is celebrated all across this country by community activities as diverse as the awarding of scholarships to deserving students, the donation of books to local libraries, blood drives, tree plantings and Health Fairs. Plans are being formulated for expanded public service projects for "National Doctors' Day."

Deadline for Renal Research Grants

Baxter Healthcare Corporation's Renal Division has set April 12, 1991 as the deadline for submission of Requests for Proposals (RFPs) for the fifth round of its Extramural Grant Program (EGP). Proposals to be funded in this round should be in two areas: 1) Beta₂-Microglobulin Amyloidosis and 2) Open category. The Open category is designed to allow scientists working in all areas of renal research the opportunity to submit RFPs.

Baxter designed the EGP to stimulate scientific advances in the understanding of kidney disease. Baxter awards approximately \$1 million in new grants annually for kidney research worldwide.

Scientific proposals are reviewed by an independent Medical Advisory Board comprised of the world's leading kidney research scientists. Review criteria is based purely on the scientific merit of the proposed research.

Modeled after the National Institutes of Health research program, the EGP has two funding cycles per year. This year's second cycle deadline is November 15, 1991. The two categories to be funded in this grant round are: 1) The Preservation of Residual Renal Function and 2) The Dialysis Patient and Nutrition.

For more information regarding Baxter Healthcare Corporation's EGP, contact Mary Hoffman at (708) 270-5201.

Notification of Defective Heart Valves

The FDA has accepted a plan by Shiley, Inc. to inform patients with certain Bjork-Shiley heart valves about rare, but potentially life-threatening defects. Physicians are also being asked to counsel patients about the risks associated with these valves and urge them to enroll in an implant registry.

The valves in question are Bjork-Shiley 60 degree Convexo-Concave (C-C) heart valves manufactured by Shiley of Irvine, CA, and implanted worldwide between 1976 and 1986. Shiley estimates that there are about 21,000 patients currently living in the United States with implanted C-C valves. Because the problem is life-threatening and new information may help patients in the future, Shiley has initiated an unprecedented program to notify patients with the implanted C-C valves.

Part of the program involves the International Implant Registry (IIR), operated by the non-profit Medic-Alert Foundation. Enrolling in the IIR will enable patients and their physicians to receive new information about the valve as it becomes available. The IIR will also provide patients with a bracelet or neck chain identifying them as prosthetic heart valve wearers in case of an emergency. The registry will be free for C-C valve patients, and all patient information in the IIR will be kept confidential.

The defect in question involves the valves' struts, which may fracture and lead to death. The overall risk of strut fractures is low (roughly 2-30 fractures per 10,000 valves per year, depending on valve size and date of manufacture), and has not changed substantially in recent years. But when a fracture does occur, it is life-threatening. Prompt replacement of the fractured valve in a facility equipped to perform open-heart surgery may increase the chance for survival. Symptoms of a valve fracture are similar to those of acute congestive heart failure or other valve problems and often take place without warning. Replacement of intact valves is not

generally performed because the risk of the procedure outweighs the risk of a fracture. Currently, no technique exists to predict which valves may fracture.

The FDA will closely monitor the Shiley notification program to ensure that physicians and patients are receiving the information they need. For more information on the strut fracture problem, call Shiley at 1-800-626-3363.

Living Wills Honored at Bates Memorial

A policy which doctors feel is a "medical legal aid" was approved recently by the board of directors at Bates Memorial Hospital.

The Do Not Resuscitate (DNR) policy is one in which patients may direct their physicians not to give them any treatment to sustain life as the result of medical complications. It is already common practice, but by adopting a policy it gives doctors something in "black and white."

Once a DNR is requested by a patient, it will be written as an order by the attending physician, who will discuss the circumstances with other physicians treating the patient.

Child Abuse Reports Increase

More than 500 abused children were treated at Arkansas Children's Hospital in 1989. If the number of abused children continues at the same rate as the first half of 1990, more than 700 abused children will be treated there this year.

All those who work with children should be aware of the signs of child abuse and neglect. Suspected cases should be reported and emergency care provided. Arkansas law provides that anyone who reports a case of suspected abuse in good faith is immune from suit for damages, even if the suspicion proves to be incorrect. Physicians are required by law to report.

The challenge is to recognize child abuse in its early stages, before the child's life is in danger.

California AIDS Testing Law Upheld

A three-judge state appeals court panel has upheld a California law requiring AIDS testing of convicted prostitutes, according to a *Washington Post* report. The December 31, 1990 decision by the 1st District Court of Appeals was the first appellate court ruling on the 1988 law. Eleven prostitutes challenged the law on the grounds that it violates their Fourth Amendment right to be free from unreasonable searches. Under the law, those who test positive for exposure to the AIDS virus are given the results, and subsequent prostitution convictions are treated as felonies. In issuing the ruling, the appeals court said although compulsory blood tests are searches subject to

the Fourth Amendment, "control of a communicable disease is a valid exercise of the state's police power." A San Francisco deputy public defender representing the prostitutes said she intends to appeal the decision to the California Supreme Court.

Health Care Access Foundation Update

As of December 1990, the Arkansas Health Care Access Foundation has provided free medical services to 2,256 medically indigent persons.

The program has 1,445 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.

PRO/SuperPRO Contract Draws Interest

The AMA PRO/SuperPRO review contract awarded last September continues to draw a great deal of interest and attention across the nation from doctors and state medical organizations. The HCFA-granted contract is designed to help resolve disagreements between the nation's Peer Review Organizations (PROs) and SuperPRO, a California based entity with a HCFA contract to review a sample of each PROs' cases. This project provides practicing physicians across the country with an opportunity to ensure that services provided under the Medicare program are appropriate to meet standards of care. The contract is unique because it allows physicians to take a direct role in the decision-making process of those cases where disagreements exist between the PRO and the SuperPRO. By seeking the objective expertise and consultation of physician volunteers, the contract allows the participating physicians to contribute to the improvement of the PRO/SuperPRO process. The AMA Physician Consultant Directory currently lists over 2,200 physicians who have expressed interest in participation in the project. The AMA matches physician participants to the distributed cases on the basis of specialty and locality. The process allows an unbiased physician to agree with the PRO or SuperPRO. The reviewer's decision, however, will not directly affect the PRO's original decision to pay or deny payment. Physicians interested in volunteering approximately one hour of time to this project should write Jane Marystone, M.D., Physician Consultant Manager, AMA, 515 North State Street, Chicago, IL 60610, or call her at (312) 464-4779.

Physician Advertising Guidelines Under Review

Guidelines for the advertising of physician services are presently under review by the Federal Trade Commis-

sion (FTC). The draft set of directives should be available for general release in the late Spring of this year following approval by the FTC. The guidelines are the work of the AMA, the American Academy of Facial, Plastic and Reconstructive Surgery, the American Academy of Dermatologic Surgery, the American Academy of Otolaryngology-Head and Neck Surgery, and the American Society of Plastic and Reconstructive Surgeons. The effort developed as a result of a resolution adopted by the AMA House of Delegates at the 1989 Annual Meeting. While not intended to be a statement on the ethics of physician advertising, the guidelines build upon the principle that physicians may ethically engage in truthful advertising, but may not engage in advertising which is false, misleading or deceptive within the meaning of Section 5 of the FTC Act 15 U.S.C., Article 45. The guidelines offer an interpretation of what constitutes truthful advertising as well as what may be considered

false, misleading or deceptive within the meaning of Section 5. As an issue, physician advertising has become increasingly important in recent years and professional and public concerns about the nature of some medical advertising continue to be raised. Some states have already responded by proposing legislation aimed at regulating certain physician advertising. Hopefully, the AMA efforts to develop these guidelines will obviate the need for such legislation. You may want to inform your legislators and the public that positive efforts are currently underway to develop and distribute these guidelines and provide for truthful physician advertising. Because of the present FTC review, and expectation that some revisions will be made to the draft in response, the draft guidelines are not yet available for release, but those with an interest or needing additional information should contact Ed Hirshfeld, (312) 464-4640 or Laura Kroll (312) 464-5601 in the AMA's Office of the General Counsel.

***Arkansas Medical Society
1991 Annual Session
Arlington Hotel
Hot Springs, Arkansas
April 25 -27, 1991***

See You on the Belle of Hot Springs!

On Friday, April 26th at 6:00 p.m., the AMS Annual Session attendees will depart on the Belle of Hot Springs for a Riverboat Cruise and Reception on the lovely Lake Hamilton. The Medical Protective Company will host this excursion on the lake.

Make plans to attend and enjoy this relaxing boat ride at the end of Friday's business and socio-economic sessions. Mark your calendar - Full Steam Ahead!



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Volume 87 Number 10

March 1991

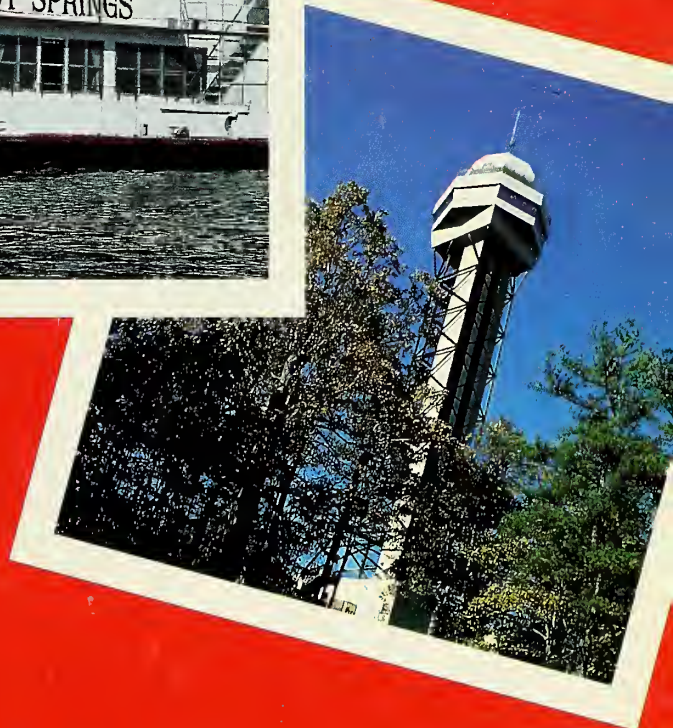
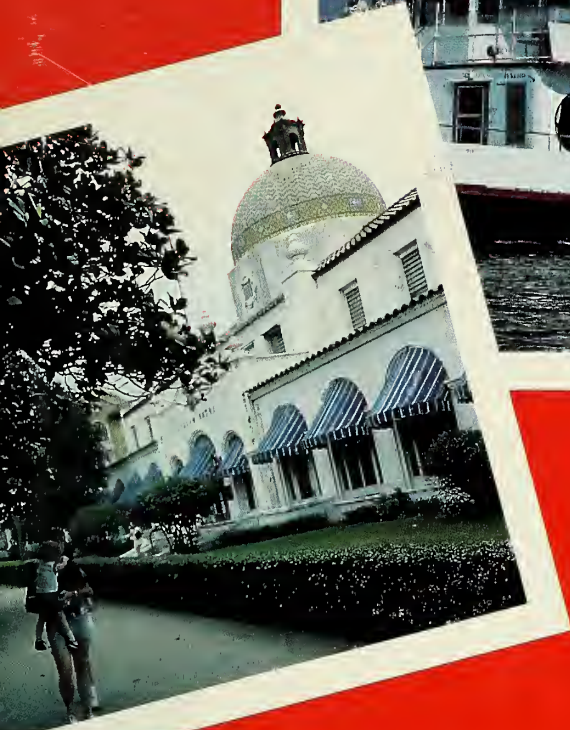
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Arkansas Medical Society
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THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

Volume 87 Number 10

March 1991

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Full Steam Ahead



Arkansas Medical Society
115th Annual Session
Hot Springs, Arkansas
April 25 - 27, 1991

Full Steam Ahead

Arkansas Medical Society Convention Program

115th Annual Session

April 25-27, 1991

Arlington Hotel and Exhibit Center
Hot Springs, Arkansas

Thursday, April 25, 1991 _____

10:00 a.m.

Golf and Tennis Tournaments

Hot Springs Country Club - Participants must pre-register.

1:00 p.m. - 5:00 p.m.

Registration

Mezzanine

3:00 p.m. - 4:45 p.m.

Council Meeting

4:00 p.m. - 6:00 p.m.

Early Arrival Hospitality Suite

AMS members, spouses, and exhibitors invited.

5:00 p.m.

House of Delegates

Keynote address:

John L. Clowe, M.D.

Speaker, AMA House of
Delegates

Schenectady, New York

7:00 p.m. - 8:30 p.m.

Blue Cross Blue Shield Reception

Friday, April 26, 1991 _____

7:30 a.m. - 5:00 p.m.

Registration

Mezzanine

8:00 a.m. - 10:30 a.m.

Reference Committee Meetings

8:30 a.m. - 10:30 a.m.

Continental Breakfast

Exhibit Center - Exhibit Area Open

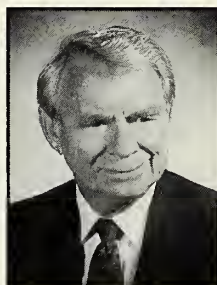
10:30 a.m. - 11:45 a.m.

First Feature Session

"Medicare Frustrations, A Doctor Fights Back"

John Ebensberger, M.D., Greene, Iowa

Tim J. Gibson, Director of Public Affairs and Medical
Services, Iowa Medical Society



John L. Clowe, M.D.



John Ebensberger, M.D.



Mr. Tim J. Gibson

12:00 noon - 1:30 p.m.

Shuffield Lecture and Luncheon

Recognition of Shuffield
Award Winner
The Honorable William E.
Dannemeyer
U.S. Representative, California



Rep. Dannemeyer

1:45 p.m. - 2:45 p.m.

Second Feature Session

Gail Wilensky, Ph.D., Administrator
Health Care Financing Administration
(Invited)

3:00 p.m. - 5:00 p.m.

Exhibit Center Open

Nickel Beer & Popcorn

3:45 p.m.

Council Meeting

6:00 p.m. - 8:30 p.m.

Riverboat Reception Cruise

Belle of Hot Springs
Hosted by The Medical Protective Company

Saturday, April 27, 1991_____

7:30 a.m. - 4:00 p.m.

Registration Open

Mezzanine

8:00 a.m.

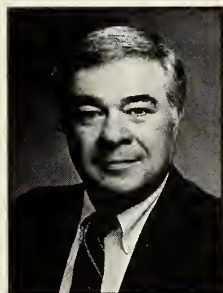
MED-PAC Breakfast

Honoring MED-PAC contributors
Sponsored by Arkansas
Regional Organ Recovery
Agency

9:00 a.m. - 10:30 a.m.

Third Feature Session

"The Doctor has AIDS: A
Patient's Right to Know"
Daniel Seckinger III, M.D.,
Miami, Florida



Daniel Seckinger, M.D.

10:30 a.m.

Exhibit Center Open

Brunch
Sponsored by James Foss and Associates

12:00 noon

Fifty Year Club Luncheon

12:45 p.m.

Grand Prize Drawing

Exhibit Center - Grand Prize: Cancun Mexico. Stay
in a five star hotel for 3 nights and 4 days. Donated
by Tours and Travel, Russellville, AR. Must be
present to win.

1:00 p.m.

AIDS Seminar

Julie Gerberding, M.D., Director
HIV Counseling and Testing Services
San Francisco General Hospital

1:00 p.m.

Specialty Meetings

Arkansas Academy of Family Physicians
Arkansas Orthopaedic Society
Arkansas Academy of Otolaryngology - Head and
Neck Surgery
Arkansas Psychiatric Society
Arkansas Society of Plastic and Reconstructive
Surgeons
Arkansas Chapter, American College of Radiology
Arkansas Urologic Society

3:30 p.m.

Memorial Service

Honoring members of the Society and Auxiliary who
have died during the past year.

4:00 p.m.

House of Delegates

7:00 p.m.

Inaugural Banquet

George Warren, M.D., will be
installed as the 1991-1992
AMS President
Master of ceremonies:
William N. Jones, M.D.
1990-1991 AMS President
Entertainment: Doc Blakely
Humorist, CPAE, author



Doc Blakely

Sunday, April 28, 1991_____

8:30 a.m.

Past Presidents Breakfast

General Information

Registration and Fees

The convention registration desk will be located on the mezzanine of the Arlington Hotel and will be staffed during the following times:

Thursday, April 25 1:00 p.m. - 5:00 p.m.
Friday, April 26 7:30 a.m. - 5:00 p.m.
Saturday, April 27 7:30 a.m. - 4:00 p.m.

No person will be admitted to any activity of the annual session without first registering. Upon checking in at the convention registration desk, you will receive a convention program, your name badge, tickets for meals and social functions, and other convention material.

	Pre-registration	On-site Registration
Member	\$60.00	\$75.00
Non-member	\$95.00	\$110.00
Spouse	\$40.00	\$55.00
No charge for students and residents		

Telephone Service

The Society will have a convention telephone at the registration desk during registration hours for your convenience. Call the Arlington Hotel operator at (501) 623-7771 and ask for the Arkansas Medical Society registration desk on the mezzanine. You may leave this number with your office personnel in case of emergencies.

Hotel Reservation Information

Call the Arlington Resort Hotel & Spa at (501) 623-7771. Be sure to tell them that you are with the Arkansas Medical Society meeting to be held April 25-27, 1991.

Cancellation Policy

All cancellations must be made in writing and received by April 18, 1991 to receive a refund. No refunds will be given after that date. All refunds, minus a \$10 processing fee, will be mailed after the conference. No refunds will be given on site.

Exhibits

Commercial and scientific exhibits will be on display in the Arlington Exhibit Center. Dr. Glen Baker, Annual

Session chairman, urges all members and their guests to take the time to visit the displays. The exhibits are a part of the educational program of the convention and provide members with the latest information on progress in pharmaceutical research, developments in instruments and equipment, insurance, accounting systems, computers, investments, and other new products and services available. The exhibits represent an important contribution to the convention. You are urged to visit each booth and let the exhibitors know you appreciate their participation.

Exhibit Hours

Friday, April 26: 8:30 a.m. - 10:30 a.m.
3:00 p.m. - 5:00 p.m.
Saturday, April 27: 10:30 a.m. - 1:00 p.m.

Continuing Medical Education Credit

As an organization accredited for continuing medical education, the Arkansas Medical Society Committee on Scientific Programs certifies that this continuing medical education activity meets the criteria for hour-for-hour credit in Category I of the Physician's Recognition Award of the American Medical Association.

Convention Officials

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William N. Jones, M.D., Little Rock, AMS president
George Warren, M.D., Smackover, AMS president-elect
Mrs. Cecil W. Cupp III, Hot Springs, convention chairman, AMS Auxiliary
Mrs. Robert L. Lewis, Hot Springs, assistant convention chairman, AMS Auxiliary



Other Meetings

Fifty Year Club Luncheon

The Society will host a luncheon for members of the Fifty Year Club at 12:00 noon, Saturday, April 27th, at the Arlington Hotel. The Fifty Year Club President is Henry V. Kirby, M.D., of Harrison. Physicians eligible for the Fifty Year Club this year are: Harold Beasley, Heber Springs; Loren O. Bohnen, Hot Springs; Robert A. Burger, Little Rock; A.D. Hall, Little Rock; John M. Hundley, Hot Springs; William E. Jennings, Rogers; Edward T. Jones, Batesville; Robert D. Jones, Little Rock; Ruth H. Junkin, Newport; Harold J. Morris, Pine Bluff; Everett C. Moulton Jr., Fort Smith; Lawrence H. Siegel, Fayetteville; James L. Smith, Little Rock; Bryant S. Swindoll, North Little Rock; R.L. Turnbow, El Dorado; Elbert H. Wilkes, Little Rock; and, Charles P. Yarbrough, Texarkana, TX.

Memorial Service

Members of the Arkansas Medical Society and Auxiliary who have died during this past year will be remembered during the Memorial Service at 3:30 p.m., Saturday, April 27th. Members to be honored are:

Society Members

Van C. Binns, Monticello
Lucas Byrd, Little Rock
Don W. Chamblin, Fort Smith
Beresford L. Church, North Little Rock
H. Blake Crow, Prescott
Onyx P. Garner Sr., New Orleans, LA
William A. Hudson, Harrison
R. Paul Hughes, Texarkana
Walter H. Lane, Dover
James G. Martindale, Hope
Ross E. Maynard, Pine Bluff
James R. Morrison, Little Rock
Thomas J. Simpson, Harrison
William J. Tolleson, Bull Shoals

Auxiliary Members and Spouses

Mrs. James A. Brown (Shirley R.), Fort Smith
Mrs. Neil Compton (Laurene P.), Bentonville
Mrs. Richard B. Dickinson (Valerie J.), DeQueen
Mrs. S.C. Fulmer (Pauline), Little Rock
Mrs. Ellery C. Gay Jr. (Doris), Little Rock
Mrs. J.G. Gladden (Willie C.), Harrison
Mrs. Fred W. Harris (Fanita), Little Rock
Mrs. Merlin J. Kilbury Sr. (Elizabeth P), Little Rock
Mrs. Harry H. Robinson (Martha), Houston, TX
Mrs. Alvin W. Strauss Jr. (Leslie), Little Rock
Mrs. Carl L. Wilson (Bette W.), Fort Smith

Past Presidents Breakfast

All past presidents and their spouses are cordially invited to a breakfast, Sunday, April 28th, at 8:30 a.m., hosted by the Society.

Specialty Meetings

Arkansas Academy of Family Physicians will participate in the Fourth Annual AIDS Seminar, Saturday, April 27th, at 9:00 a.m.

Arkansas Orthopaedic Society will meet Saturday, April 27th, at 1:00 p.m., at the Park Hilton Hotel. Program: "Congressional Proposals Concerning Medicaid," Marilyn Weiseberg, Policy Analyst, American Academy of Orthopaedic Surgeons.

Arkansas Academy of Otolaryngology - Head and Neck Surgery will meet Saturday, April 27th, at 1:00 p.m. The meeting will begin with a luncheon/business meeting followed by an educational program.

Arkansas Psychiatric Society will participate in the Fourth Annual AIDS Seminar, Saturday, April 27th, at 9:00 a.m.

Arkansas Society of Plastic and Reconstructive Surgeons will meet Saturday, April 27th, at 1:00 p.m.

Arkansas Chapter, American College of Radiology will meet Saturday, April 27th. The executive committee will meet at 1:00 p.m., followed by a general business meeting at 2:00 p.m.

Arkansas Urologic Society will meet Saturday, April 27th, at 11:00 a.m. Guest speaker: Ananias Diokno, M.D., chief of Urology at the William Beaumont Hospital in Royal Oak, Michigan.

Arkansas State Medical Board

The Arkansas State Medical Board will meet during the Annual Session. Times and days will be announced at a later date.

Arkansas State Board of Health

The Arkansas State Board of Health will meet Friday, April 26th, at 12:00 noon, in the hotel.

Targeting Volunteerism and Building Community Partnerships

Arkansas Medical Society Auxiliary

67th Annual Session

April 25-27, 1991

The Arlington Hotel

Hot Springs, Arkansas

Registration _____

Mezzanine

Thursday 1:00 p.m. - 5:00 p.m.

Friday 7:30 a.m. - 5:00 p.m.

Saturday 7:30 a.m. - 4:00 p.m.

Official honorary hostesses for the 67th Annual Session are past presidents of the Arkansas Medical Society Auxiliary.

Thursday, April 25, 1991 _____

10:00 a.m. - 3:00 p.m.

Arkansas Leadership Confluence for State and County Officers

(Arrangements are being made by Mrs. Charles Rodgers, President-elect; details announced later)

3:00 p.m.

Pre-Convention Board Meeting

Magnolia Room - All State Officers, State Committee Chairmen, County Presidents, County President-elects, and Past State Presidents. All new Board members for 1991-92 are cordially invited to attend.

7:00 p.m.

Blue Cross Blue Shield Reception

Friday, April 26, 1991 _____

8:00 a.m.

Continental Breakfast

Magnolia Room - Members and guests are invited.

8:30 a.m.

"Arkansas Adolescent and Teen Health Concerns"

Joycelyn Elders, M.D., Director
Arkansas Department of Health

9:30 a.m.

Opening General Session

Magnolia Room - Mrs. David Williams, President, presiding

General Business, Roll Call, and Seating of County Delegates Introduction of Special Guests:

Mrs. Joe Ed Smith
Mrs. William D. Shelton
John Lee Clowe, M.D.
William Jones, M.D.
Mr. Ken LaMastus
Ms. Peggy Pryor Cryer

Address:

Mrs. Joe Ed Smith
Director, Southern Region
American Medical
Association Auxiliary



Mrs. Joe Ed Smith

Convention Announcements:

Mrs. Cecil Cupp, Convention Chairman

Reports of Officers and

Committee Chairmen

Unfinished Business

New Business

Election of the Nominating Committee

(2 from the Board; 2 from the House of Delegates)

Election of Delegates and Alternates to the 1991 American Medical Association Auxiliary Convention.

Presentation of the 1991-92 Budget:

Mrs. Jim Garner, Finance Chairman

Adjournment

12:00 noon

Shuffield Lecture and Luncheon

Ballroom - Recognition of Award Winner
The Honorable William E. Dannenmeyer
U.S. Representative, California

2:00 p.m.

Historic Downtown Walking Tour

Tour art galleries and antique shops. Pre-arranged facial or bath massage at the Arlington Hotel.

4:00 p.m.

Afternoon Tea

Historic Stitt House Restaurant

6:00 p.m.

Riverboat Reception Cruise

Belle of Hot Springs

Saturday, April 27, 1991_____

8:00 a.m.

Past Presidents' Breakfast

Fountain Room

8:15 a.m.

Continental Breakfast

Magnolia Room - Members and Guests

8:45 a.m.

"Health Youth 2000"

Arvil Burks, Ed.D.

University of Central Arkansas, Conway

Gary Parish, Program Advisor

Comprehensive School Health

State Department of Education

9:30 a.m.

Second General Session

Magnolia Room

Mrs. David Williams,

President, Presiding

General Business

Greetings from Southern:

Mrs. William D. Shelton,

President-elect

Southern Medical

Association Auxiliary

Reports by County Presidents:

Moderators: District Vice Presidents

Northeast: Mrs. Don Vollman

Northwest: Mrs. Robert P. Hughes

Southeast: Mrs. David Jacks

Southwest: Mrs. Dale Kincheloe

Unfinished Business

New Business

Nominating Committee Report: Mrs. Larry Lawson

Election of Officers

Adjournment

12:15 p.m.

Luncheon

Majestic Hotel, Grady Manning Dining Room

Hostess: Pulaski County

Invocation

Presiding: Mrs. David Williams, President

Introduction of Guests

Presentation of Awards:

AMA-ERF:

Mrs. Jerry Holton, Chairman

Vinne E. Garrison Memorial Award:

Mrs. Joe Crumpler, Chairman

Membership Award:

Mrs. Charles Rodgers, Chairman

Doctors' Day Award:

Mrs. David Jacks, Southern Medical Auxiliary
Councilor

Installation of Officers:

Mrs. Joe Ed Smith, Director, Southern Region
American Medical Association Auxiliary

2:30 p.m.

Post Convention Board Meeting

Majestic Hotel

3:45 p.m.

Memorial Service

7:00 p.m.

Inaugural Banquet

Ballroom



Mrs. William D. Shelton

Scenes From the 1990 Annual Session Arlington Hotel Hot Springs, Arkansas



Convention Registration Form



Dr. _____
(Please Print)

Mr./Mrs. _____
(First and Last Name)

Title _____
(Delegate, Officer, Councilor)

Specialty _____

Address _____

City _____ State _____ Zip _____ County _____

Registration Information

AMS Member and Spouse fees cover the Shuffield Luncheon, Inaugural Banquet, Exhibit Center Continental Breakfast, Exhibit Center Brunch, and entrance into the Exhibit Center.

No one will be allowed in the Exhibit Center without a registration badge.

Registration Fees:

	Pre-Paid	On-Site
Member	\$60.00	\$75.00
Spouse	\$40.00	\$55.00
Auxiliary Luncheon	\$15.00	\$20.00
Auxiliary Tea	\$10.00	\$15.00
Non-Member	\$95.00	\$110.00

Students/Residents - No Charge with proper ID

Additional Tournament Charges (Optional):

Participants must pre-register. Fees are per person.

Golf \$55.00 Tennis \$30.00

For appropriate meal count, please check if you will be attending:

_____ Shuffield Luncheon _____ # Attending

_____ Inaugural Banquet _____ # Attending

Total Amount Enclosed \$ _____

Checks for member, spouse, and auxiliary registration should be made payable to and forwarded with the registration form to:

Arkansas Medical Society
P.O. Box 5776
Little Rock, AR 72215



House of Delegates

The opening session of the House of Delegates of the Arkansas Medical Society will begin at 5:00 p.m. on Thursday, April 27th. Speaker of the House John Crenshaw, M.D., will preside, assisted by Vice Speaker Kelsy J. Caplinger III, M.D.

All items of business to be considered by the House must either be printed in the convention issue of *The Journal* or submitted to the headquarters office in writing 20 days prior to the meeting. Any new business proposed during the session of the House of Delegates must have a two-thirds vote of attending delegates for introduction.

Items of business will be referred by the Speaker of the House of Delegates to one of two reference committees. Open hearings on those items of business will be held by the reference committees on Friday, April 26th at 8:00 a.m. All members of the Society are welcome to attend the meetings of the reference committees and to express views on the various reports, resolutions, etc.

The following will be seated at the House of Delegates meeting during the 1991 Annual Session:

Officers

John Crenshaw, Pine Bluff, speaker, (ex-officio)
Kelsy J. Caplinger III, Little Rock, vice speaker, (ex-officio)
William N. Jones, Little Rock, president (ex-officio)
George Warren, Smackover, president-elect (ex-officio)
Michael N. Moody, Salem, first vice president (ex-officio)
Charles H. Rodgers, Little Rock, secretary (ex-officio)
James M. Kolb Jr., Russellville, treasurer (ex-officio)

District 9: Robert H. Langston, Harrison
David L. Rogers, Fayetteville
District 10: Morton C. Wilson, Fort Smith
Gerald A. Stolz, Russellville
A. C. Bradford, Fort Smith

Past Presidents (ex-officio)

Charles R. Henry Sr., Little Rock
Joe Verser, Harrisburg
C. Randolph Ellis, Malvern
Joseph A. Norton, Little Rock
H. W. Thomas, Dermott
Ross E. Fowler, Harrison
C. Stanley Applegate Jr., Springdale
C. Robert Watson, Little Rock
John P. Wood, Mena
Ben N. Saltzman, Little Rock
T.E. Townsend, Pine Bluff
Albert S. Koenig Jr., Fort Smith
W. Payton Kolb, Little Rock
George F. Wynne, Warren
A.E. Andrews Jr., Texarkana
Kemal E. Kutait, Fort Smith
Purcell Smith Jr., Little Rock
Morris M. Henry, Fayetteville
Asa A. Crow, Paragould
Charles F. Wilkins Jr., Russellville
John P. Burge, Lake Village
C.C. Long, Fort Smith (honorary)
Ken Lilly, Fort Smith
W. Ray Jouett, Little Rock
John M. Hestir, DeWitt
James R. Weber, Jacksonville

Councilors

District 1: J. Larry Lawson, Paragould
Merrill J. Osborne, Blytheville
District 2: John E. Bell, Searcy
Jim E. Lytle, Batesville
District 3: L. J. P. Bell, Helena
Hoy B. Speer Jr., Stuttgart
District 4: Paul A. Wallick, Monticello
Lloyd G. Langston, Pine Bluff
District 5: Cal R. Sanders, Camden
Wayne G. Elliott, El Dorado
District 6: James D. Armstrong, Ashdown
F. E. Joyce, Texarkana
District 7: Ronald J. Bracken, Hot Springs
Thomas H. Hollis, Hot Springs
District 8: Glen F. Baker, Little Rock
David L. Barclay, Little Rock
Paul Cornell, Little Rock
Warren Douglas, Little Rock
Charles Logan, Little Rock
R. Jerry Mann, Little Rock
Harold Purdy, Little Rock

Ex-officio members shall have the power of voting on all subjects except the election of officers.

Delegates for 1991 (as submitted by county)

	<u>Delegate</u>	<u>Alternate Delegate</u>
Arkansas (1)	Dennis B. Yelvington	Noble B. Daniel
Ashley (1)	D.L. Toon	Curtis E. Ripley
Baxter (1)		
Benton (3)	William T. Summerlin Stephen L. Goss Larry Wright	
Boone (1)	John T. Troupe	Carlton L. Chambers
Bradley (1)	Joe H. Wharton	George F. Wynne
Carroll (1)		
Chicot (1)	Tom Tvedten	John Jackson
Clark (1)	Noland H. Hagood	James L. Lowry
Cleburne (1)	J. Warren Murry	
Columbia (1)	H. Scott McMahan	John E. Alexander Jr.
Conway (1)		
Craighead/ Poinsett (5)	Jerry D. Blaylock Joe H. Stallings Jr. Don B. Vollman Jr.	
Crawford (1)		
Crittenden (1)	Steve P. Schoettle	Edgar S. Ferguson
Cross (1)		
Dallas (1)	Don Howard	Hugh A. Nutt
Desha (1)	Howard R. Harris	Guy U. Robinson
Drew (1)		
Faulkner (1)	Jimmy J. Magie	Robert B. Rook
Franklin (1)		
Garland (5)	Cecil W. Cupp III Mark Russell Doane M. Newton Rheeta M. Stecker James L. Gardner	
Grant (1)		
Greene/ Clay (1)		
Hempstead (1)		
Hot Spring (1)		
Howard/ Pike (1)	Joe D. King	Robert R. Sykes
Independence (2)	Lloyd G. Bess John R. Baker	
Jackson (1)		
Jefferson (4)	Simmie Armstrong Jr. Lee A. Forestiere Kenneth A. Martin Anna T. Ridling	
Johnson (1)		
Lafayette (1)	Sanford E. Hutson	
Lawrence (1)	Ralph F. Joseph	Sebastian A. Spades III
Lee (1)		
Little River (1)	Robert D. Dalby	Joseph G. Shelton Jr.
Logan (1)	John R. Williams	Guy Ulrich
Lonoke (1)	Jerry C. Chapman	Leslie F. Anderson
Miller (3)	Donald L. Duncan Herbert B. Wren	John A. Gillean F.E. Joyce
Mississippi (1)		
Monroe (1)	Neylon C. David	Linda F. Collins
Nevada (1)	Charles Vermont	
Ouachita (1)	William D. Dedman	R.H. Nunnally
Phillips (1)	L.J.P. Bell	Robert D. Miller Jr.

	<u>Delegate</u>	<u>Alternate Delegate</u>
Polk (1)	Byron Page	David D. Fried
Pope (2)	Stanley C. Bradley Kelly H. Meyer	William G. Barron Mike Hendren
Pulaski (29)	Durwood B. Allen Jr. Joseph Beck II Raymond V. Biondo Amail Chudy Gilbert O. Dean Marlon Doucet Jim English Charles P. Fitzgerald James L. Hagler Edwin Hankins III Fred O. Henker III D. Andrew Henry Marvin Leibovich Fred G. Nagel George A. Norton Walter O'Neal J. Mayne Parker John D. Pike Carl J. Raque John F. Redman William H. Riley Ashley S. Ross Jr. Bruce E. Schratz Robert F. Shannon Frank M. Sipes William L. Steele Wanda J. Stephens Robert Valentine Jr. Thomas Wortham	James H. Adametz John W. Baker John P. Brizzolara Lillian Cavin Bob E. Cogburn Lisa A. Cosgrove Bryon D. Curtner Phillip J. Deer III Cynthia N. Frazier David L. Gilliam William E. Golden A. David Hall HGraves Hearnberger J. Timothy Hodges Jerry C. Holton Coburn S. Howell Harold G. Hutson G. Thomas Jansen John C. Jones Stephen K. Magie Michael C. Roberson Edward H. Saer Peter G. Singer G. Emory Warren Samuel B. Welch Pamela J. Wills Virgil D. Wooten Ruel N. Wright Paul W. Zelnick
Randolph (1)		
Saline (1)	Marvin N. Kirk Jr.	Frank E. Thibault Jr.
Sebastian (9)	Jimmy D. Acklin A. Samuel Koenig III Kevin Phillips Sumer A. Phillips Eugene Still Jerry R. Stewart John R. Swicegood Carl L. Williams Paul I. Wills Jonathan Hoyt	Randy Ennen R. Cole Goodman Jr. David W. Hunton David B. Kocher John R. Lange Andre J. Nolewajka McDonald Poe Jr. John D. Wells John H. Wikman
Sevier (1)		
St. Francis (1)		
Tri-County (1)	A.M. Grasse	Thomas H. Benton
Union (2)		
Van Buren (1)	John A. Hall	Charles G. Pearce
Washington (5)	Hershel Garner William B. Nowlin Janet L. Titus	
White (2)		
Woodruff (1)	James E. Rowe	
Yell (1)	James L. Maupin	
Resident Physician Section (1)		
Medical Student Section (1)	Katherine Henry	Elise Fortin

First Meeting, House of Delegates

5:00 p.m., Thursday, April 25th

John Crenshaw, M.D., Speaker

Kelsy J. Caplinger III, M.D., Vice Speaker

Final Meeting, House of Delegates

4:00 p.m., Saturday, April 27th

John Crenshaw, M.D., Speaker

Kelsy J. Caplinger III, M.D., Vice Speaker

1. Call to order
2. Presentation of the Colors
3. Welcome to Hot Springs
4. Introduction of guests:
 - Mrs. Joe Ed Smith
Southern Regional Director
American Medical Association Auxiliary
 - Mrs. William B. Shelton Jr.
President-elect
Southern Medical Association Auxiliary
 - Mrs. David Williams, President
Arkansas Medical Society Auxiliary, Russellville
 - Mrs. Charles Rodgers, President-elect
Arkansas Medical Society Auxiliary, Little Rock
5. Address by John L. Clowe, M.D.
Speaker
House of Delegates,
American Medical Association, Schenectady, NY
6. Adoption of minutes of the 114th Annual Session as published in the June 1990 issue of *The Journal of the Arkansas Medical Society*.
7. Presentations
8. Old Business
 - Warren Douglas, M.D., chairman of the Task Force on Constitutional Revision, will present proposed amendments to the Constitution and Bylaws for final consideration of the House (Amendments represent major revisions in the Constitution and Bylaws. The full text of the revision begins on page 426).
9. New Business
 - All reports, resolutions, and other items of business received by the headquarters office 20 days prior to the meeting shall be included in the agenda. Any items of business received after April 5th, must have two-thirds consent of attending delegates before introduction. All items will be referred to reference committees.
9. Announcement of vacancies on State Boards:
 - Arkansas State Medical Board (Sixth Congressional District)
 - Arkansas State Board of Health (Third and Sixth Congressional Districts and Member-at -Large)
10. Recess until Saturday

1. Call to order
2. Election of officers. Nominations as submitted by the Nominating Committee:
 - President-elect:
 - J. Larry Lawson, M.D., Paragould
 - Asa Crow, M.D., Paragould
 - First Vice President:
 - Michael N. Moody, M.D., Salem
 - Second Vice President:
 - Anna T. Ridling, M.D., Pine Bluff
 - Third Vice President:
 - William L. Rutledge, M.D., Little Rock
 - Treasurer:
 - James M. Kolb Jr., M.D., Russellville
 - Secretary:
 - Charles H. Rodgers, M.D., Little Rock
 - Speaker of the House:
 - John Crenshaw, M.D., Pine Bluff
 - Vice Speaker of the House:
 - Kelsy J. Caplinger III, M.D., Little Rock
 - Delegates to the AMA (1/1/92 - 12/31/93)
 - W. Payton Kolb, M.D., Little Rock
 - Alternate Delegates to the AMA (1/1/92-12/31/93):
 - Asa Crow, M.D., Paragould
 - Councilors:
 - District 1:
 - Merrill J. Osborne, M.D., Blytheville
 - District 2:
 - Jim E. Lytle, M.D., Batesville
 - District 3:
 - Hoy B. Speer Jr., M.D., Stuttgart
 - District 4:
 - Lloyd G. Langston, M.D., Pine Bluff
 - District 5:
 - Wayne G. Elliott, M.D., Camden
 - District 6:
 - F.E. Joyce, M.D., Texarkana
 - District 7:
 - Thomas H. Hollis, M.D., Hot Springs
 - District 8:
 - Glen F. Baker, M.D., Little Rock
 - Paul J. Cornell, M.D., Little Rock
 - Charles W. Logan, M.D., Little Rock
 - Robert F. Shannon, M.D., Little Rock

District 9:

David L. Rogers, M.D., Fayetteville

District 10:

A.C. Bradford, M.D., Fort Smith

3. Address by Past President of the Arkansas Medical Society, William N. Jones, M.D.
4. Reports of Reference Committees:
Committee #1
Committee #2
5. Supplemental report of the Council:
J. Larry Lawson, M.D., Chairman
(Report covers meetings of the Council held during the annual session.)
6. New Business:
Announcement of nominees for the Arkansas State Medical Board and the Arkansas State Board of Health
Other new business

State Board Vacancies

Arkansas State Board of Health

A vacancy will occur December 31, 1991, in the Third and Sixth Congressional Districts and the Member-at-Large position of the Arkansas State Board of Health. Members from the counties in the district are urged to meet immediately following the adjournment of the House of Delegates on Thursday to vote for nominees. The term of office is four years. Nominations should be reported to the Society personnel immediately following the caucuses (only one nomination is required).

Third Congressional District: Ken Lilly, of Ft. Smith, is currently serving the term which will expire in December 1991. Dr. Lilly is eligible to succeed himself.

Counties in the Third Congressional District include Baxter, Benton, Boone, Carroll, Crawford, Franklin, Johnson, Logan, Madison, Marion, Newton, Scott, Searcy, Sebastian, Van Buren, and Washington.

Sixth Congressional District: Howard R. Harris, of Dumas, is currently serving the term which will expire in December 1991. Dr. Harris is eligible to succeed himself.

Counties in the Sixth Congressional District include Arkansas, Chicot, Cleveland, Dallas, Desha, Drew, Garland, Grant, Hot Spring, Jefferson, Lincoln, Lonoke, and Saline.

Arkansas State Medical Board

A vacancy will occur December 31, 1991, in the Sixth Congressional District position of the Arkansas State

Medical Board. The term of office will be for eight years. Members from the counties in the district are urged to meet immediately following the adjournment of the House of Delegates on Thursday to vote for nominees. Nominations should be reported to the Society personnel immediately following the caucuses (only one nomination is required).

Sixth Congressional District: James Gardner, M.D., of Hot Springs, is currently serving the term which will expire in December 1991. Dr. Gardner is eligible to succeed himself.

Counties in the Sixth Congressional District include Arkansas, Chicot, Cleveland, Dallas, Desha, Drew, Garland, Grant, Hot Spring, Jefferson, Lincoln, Lonoke, and Saline.

Meetings of the Council

The Council will meet at the following times:

Thursday, April 25	3:00 p.m.
Friday, April 26	3:45 p.m.

Third Council meeting will be called at the discretion of the Chairman if needed.

Reference Committees

Reference Committees are appointed by the Speaker of the House of Delegates to consider the various reports and resolutions. Reports published in this issue of *The Journal*, as well as any reports and resolutions presented at the first meeting of the House on April 25th, will be referred by the Speaker to the reference committees. The committees will hold open hearings at 8:00 a.m. on Friday, April 26th. After the hearings, the reference committees will hold executive sessions for the purpose of preparing recommendations and reports for the House of Delegates. Reports of the Reference Committees will be acted upon by the House of Delegates at the Saturday session.



MODULATE/DEMULATE
MODEM **ETHERNET** SINGLE USER
EGA CLEARING HOUSE
PC-XT/AT XENIX **BI - SYNCHRONIS**
CGA **ELECTRONIC CLAIMS SUBMISSION**
MEGAHERTZ RAM REMOTE ACCESS VGA **UNIX**
ASYNCHRONIS MEGABYTES ROM **ARCNET**

SERIAL PORTS **MIPS**
HIGH DENSITY
TACTILE HARD DISK
WORKSTATIONS VGA

9 PIN DOT MATRIX DATA TRANSFER
UNATTENDED POLING **CPS**

BARCODE RE

DOS PARALELL INTERFACE

MAGNETIC MEDIA **MGA**

MONOGRAPHIC ADAPTER
LOCAL PRINTER **BAUD RATE**
AT COMPATIBLE

WORM DRIVE A-B SWITCH

WEDGE **DATA TERMINALS**

MULTI-USER ENVIROMNEN

NETWORKING

ACCEPT ASSIGNMEN

CROSSOVER CLAIM **EDS**

CHARGE SLIPS HMO WRITE-OFF
CURRENT PROCEDURAL TERMINOLOGY

OUTSIDE LAB CHARGES

SUPERBILL PPO

WORKMAN'S COMP

ICD DIAGNOSIS CODES

REFERRING PHYSICIAN SECONDARY

GROUP NUMBER **HICFA**

PLACE OF SERVICE CODE
PRIMARY CARRIER

PRIOR AUTHORIZATION
TYPE OF SERVICE CODES

SAME/SIMILIAR INDICATOR

PATIENT CHARTS DAY SHEETS

SUPERBILL

CPT PROCEDURE CODES

WAITING **LEDGER CARDS**

ROOM INSURANCE CARDS GROUP PLOICY NUMBER

DISABILITY PATIENT STATEMENTS RELATIONSHIP TO THE INSURED

APPROVED AMOUNT

APPOINTMENT BOOK EXAMINATION ROOM TICKLER FILES
SELF PAYS MEDICAID ATTENDING PHYSICIAN PPO/HMO
DATE OF ACCIDENT **PATIENT RECORDS**

ELECTRONIC CLAIMS

STRAIGHT TALK.

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YOUR LANGUAGE.



1-800-628-8274

WRITE-OFF PARTICIPATING PHYSICIAN
MEDICARE
CHARGE SLIPS
PAYER PAYMENT
DATE OF DISABILITY
RESPONSIBLE PARTY
INDIVIDUAL POLICY NUMBER

Nominating Committee

Nominating Committee

Charles Logan, M.D., Chairman

The Nominating Committee met September 29, 1990, at the Arkansas Medical Society office in Little Rock in conjunction with the Razorback football game; October 27, 1990, during the fall meeting of the Arkansas Medical Society in Pine Bluff; and by conference call on November 28, 1990. We wish to present to the Society the following nominees:

President-elect:

J. Larry Lawson, M.D., Paragould

Asa Crow, M.D., Paragould

First Vice President:

Michael N. Moody, M.D., Salem

Second Vice President:

Anna T. Ridling, M.D., Pine Bluff

Third Vice President:

William L. Rutledge, M.D., Little Rock

Treasurer:

James M. Kolb Jr., M.D., Russellville

Secretary:

Charles H. Rodgers, M.D., Little Rock

Speaker of the House:

John Crenshaw, M.D., Pine Bluff

Vice Speaker of the House:

Kelsy J. Caplinger III, M.D., Little Rock

Delegate to the AMA (1/1/92 - 12/31/93)

W. Payton Kolb, M.D., Little Rock

Alternate Delegate to the AMA (1/1/92 - 12/31/93):

Asa Crow, M.D., Paragould

Councilors:

District 1:

Merrill J. Osborne, M.D., Blytheville

District 2:

Jim E. Lytle, M.D., Batesville

District 3:

Hoy B. Speer Jr., M.D., Stuttgart

District 4:

Lloyd G. Langston, M.D., Pine Bluff

District 5:

Wayne G. Elliott, M.D., Camden

District 6:

F.E. Joyce, M.D., Texarkana

District 7:

Thomas H. Hollis, M.D., Hot Springs

District 8:

Glen F. Baker, M.D., Little Rock

Paul J. Cornell, M.D., Little Rock

Charles W. Logan, M.D., Little Rock

Robert F. Shannon, M.D., Little Rock

District 9:

David L. Rogers, M.D., Fayetteville

District 10:

A.C. Bradford, M.D., Fort Smith

Nominating Committee Supplemental Report

In the event of the election of J. Larry Lawson, M.D., as president-elect, the First Councilor District recommends Dwight M. Williams, M.D., of Paragould, to complete Dr. Lawson's unexpired term as Councilor ending April 1992.

See You in Hot Springs!



Business Reports

Committee on AIDS

Joseph M. Beck II, M.D., Chairman

The Arkansas Medical Society Committee on AIDS held 10 formal meetings during 1990. The hallmark of this committee has continued to be the excellent enthusiastic participation and contribution of its members. During 1990, the committee members were: Drs. Joseph Beck II, chairman, William N. Jones, A. Stuart Fitzhugh, Donald C. Fournier, Harold Hedges, Charles R. Henry Sr., Linda A. Markland, Eugene M. Shelby, E. Clinton Texter Jr., Jimmy Acklin, Doug Wilson, Mrs. Arleta Power, Auxiliary representative, Lee Fleming and Tim Coalwell, medical student representatives.

It is quite evident that the AIDS epidemic continues to accelerate and is expanding into new risk groups — women and children. While HIV infections in gay men is stabilizing or, in some areas of the country declining per capita population, HIV infection is exploding in women of childbearing age and in children. The Committee on AIDS has been sensitive to the changes in demographics and has attempted to expand its activities to address these issues.

In the United States, there have been more than 156,024 cases and over 100,813 deaths from AIDS reported to the Centers for Disease Control since 1981. The state of Arkansas has experienced an explosive increase in the number of AIDS cases this year which underscores the need for intense educational efforts on treatment and prevention.

The year 1990 has produced no breakthroughs in treatment of the HIV disease. Zidovudine continues to be the gold standard anti-retroviral therapy, although new agents including ddI are being tested.

Activities of the Committee include:

Collaboration with the Arkansas Department of Education, Arkansas Department of Health, the President's Commission on AIDS, Dallas County Hospital, RAIN, AMA, Arkansas AIDS Foundation, Fighting AIDS Through Education (FATE), Centers for Disease Control, Arkansas Care Givers Group, Delta Regional AIDS Training Center, Arkansas State Dental Association, Arkansas State Nurses Association, FDA, and the United States Congress.

Fifty educational programs on AIDS were conducted which reached over 6,700 people. Of the 50 educational programs, 17 were FATE programs (medical students speaking to high schools). Presentations were given to groups such as Catholic High School, Westark Community College, Regional Hemophilia Association, County Line High School, Regional Interfaith AIDS Network, AHEC, nursing groups, and 21 Arkansas Department of Education

cooperative programs. The cooperative programs were conducted in Arkadelphia, Pine Bluff, Harrison, Van Buren, Fayetteville (twice - 19 school districts), Atkins, Westside, Altus-Denning (twice), Mulberry, Pleasant Grove, Batesville, Ozark, and Conway.

Over 125 health professionals attended the 1990 Third Annual AIDS Seminar. The keynote speaker was Dr. Marcus Conant, a pioneer in AIDS education in California. Breakout sessions on psychosocial issues, HIV infection in the health care settings, and dental issues in HIV infection were held.

Through the efforts of AMS officers and councilors who wrote local organizations offering AIDS educational programs, five programs were presented (two in Russellville, one in Atkins, one in Blytheville, and one in Fayetteville).

The Committee continues to address the issue concerning the lack of requirement by blood plasma centers to notify donors who test HIV positive. The Committee has written the Centers for Disease Control, Dr. Louis Sullivan of the Department of Health and Human Services, and has drafted proposed legislation which will be considered at the 1991 Arkansas General Assembly.

On April 19, 1990, Dr. William N. Jones, AMS president and a member of the Committee on AIDS, testified before the United States House of Representatives' Subcommittee on Health and the Environment. Dr. Jones spoke at the invitation of Congressman William E. Dannemeyer (Democrat/California). Dr. Jones addressed the importance of contact tracing and partner notification for the control of the spread of the AIDS virus. Excerpts from Dr. Jones remarks were featured on CNN television news broadcast.

In June, the Society surveyed members and nonmembers concerning AIDS and HIV disease. Over 1,000 responses were received (an approximate 27% return rate) and the results tabulated by Miller Research Group. At the request of Dr. Robert Bradsher, Anita Gottlieb, a registered nurse practitioner from Arkansas Children's Hospital, is working with others to compile the statistical information into an article that will be published in *The Journal of the Arkansas Medical Society*.

During 1990, following articles were published in *The Journal of the Arkansas Medical Society*:

"HIV Blood Test Counseling" by Robert C. Rinaldi, Ph.D. and John J. Henning, Ph.D.

"The System Works If You Are Willing to Work the System" by William N. Jones, M.D.

"HIV Infection in Health Care Workers - What are the Risks?" by Joseph Beck II, M.D. and Rebecca E. Martin, M.D.

"Management of Psychiatric Aspects of HIV Infection" by Charles Billings, M.D., director of Psychiatry Residency Training at Oschner Clinic

"Physicians with AIDS" by Leo Uzych, J.D., M.P.H.

"RAIN in Arkansas" by Trudy James

"New Information on ddI", published from information received from the National Institute of Health

The Committee has begun planning the Fourth Annual AIDS Seminar which will coincide with the Arkansas Medical Society Annual Session in Hot Springs, this April. The keynote speaker will be Dr. Julie Gerberding, an infectious disease specialist from San Francisco General Hospital. Dr. Gerberding is an internationally recognized expert in HIV issues among health care workers including nosocomial infections.

Annual Session Committee

Glen F. Baker, M.D., Chairman

"Taking Aim at Doctors - The Trauma of a HCFA Sanction", "Missing the Mark on Patient Care - The Horrors of a Third-Party Utilization Review", "Oregon's Medicaid Program - An Effort at Access", and a "Profile for the 21st Century" were topics used to express ways we were "Targeting Medicine in the 90's".

Dr. Michael Burditt of Victoria, Texas, discussed his own traumatic experience of a HCFA sanction due to the "patient dumping law". Senator Bill Bradbury of Brandon, Oregon, outlined Oregon's innovative "Effort at Access to Care" while Henry Cisneros, past mayor of San Antonio, Texas, detailed the changing demographics in America while providing insight to the composition of patient waiting rooms in the decades ahead.

Our two and one-half day program was informative, enlightening, as well as entertaining. Each speaker addressed the Society with a great deal of knowledge and expertise of his topic while expressing caution to what seems to be in the future.

We had 441 physicians and spouses attend the exhibit hall, meetings and banquets as 215 exhibitors worked the 60 booths. As a result of the exhibit booth space fees and other contributions and grants, the annual session was again able to finance itself rather than deplete the Society's general operating budget.

Budget Committee

James Armstrong, M.D., Chairman

The Budget Committee submitted the following budget for 1991. The complete budget, as presented to the Council, is available to members upon request.

<i>Income</i>	<i>Amount Budgeted</i>
AMS Dues	\$560,000.00
Journal Advertising	62,000.00
Booth Income	28,000.00
Annual Session	23,000.00
AMA Reimbursement	6,500.00
Miscellaneous & Rosters	10,000.00
Interest Income	70,000.00
Specialty Desk	2,000.00
CME	1,200.00
Rent, F.O. & Land Income	56,360.00
*Allocation G.A. Department	5,000.00
Educational Programs	<u>3,000.00</u>
Total	\$827,060.00

<i>Expenses</i>	
Salaries	\$231,717.00
Travel & Convention	48,000.00
President's Account	4,000.00
Taxes	25,500.00
Retirement	26,500.00
Stationary & Printing	12,500.00
Office Supplies & Expenses	21,000.00
Telephone & Telegraph	10,000.00
Rent	140,000.00
Postage	22,500.00
Insurance & Bonds	41,300.00
Auditing	4,125.00
Council & Executive Committee	3,500.00
Journal Expense	56,000.00
Dues & Subscriptions	3,000.00
Gifts & Contributions	2,200.00
Auxiliary	2,000.00
Legal Services (Retainer)	28,100.00
Special Committee	2,340.00
Public Relations	3,000.00
Miscellaneous Expenses	4,000.00
Office Equipment & Furniture	8,000.00
CME	1,000.00
Richmond Early Retirement	5,820.00
Contract Labor	750.00
AMS Resident & Student Section	5,500.00
AIDS Committee	5,000.00
Annual Session	47,500.00
Educational Programs	1,000.00
Building Fund	30,000.00
Physicians' Health Committee	10,000.00
MEFFA - Dues	<u>2,400.00</u>
Total	\$815,252.00

Department of Governmental Affairs

Income \$188,000.00

Expenses

Salaries	\$ 77,250.00
Retirement	8,600.00
Taxes	6,900.00
Stationary & Printing	5,000.00
Office Supplies, Phone, Misc.	4,250.00
Equipment & Furniture	1,500.00
Auto, Travel, & Meetings	42,000.00
Legal Retainer	18,300.00
Postage	10,000.00
Insurance & Bonds	7,500.00
Office Allocation to AMS	5,000.00
Audit	<u>750.00</u>
Total	\$187,050.00

Report of the Council

J. Larry Lawson, M.D., Chairman _____

The Council met Sunday, March 4, 1990, at the Holiday Inn West in Little Rock and the following business was transacted:

1. Approved the minutes of the November 19, 1989, Council meeting as printed in the April 1990 issue of *The Journal of the Arkansas Medical Society*.
2. Approved the minutes of the January 24, 1990, Executive Committee as follows:
 - a. The Committee heard a report from Mrs. W. Ray Jouett of the Arkansas Medical Society Auxiliary's DWI project. The Committee was complimentary of the auxiliary and their efforts in this program. They suggested we run an article about the program in *The Journal of the Arkansas Medical Society* with the indication that the Executive Committee had recognized the outstanding work of the auxiliary on this project.
 - b. Received a report on the number of referrals for the Arkansas Health Care Access Foundation.
 - c. Heard a report on those attending the Leadership Conference of the AMA in February 1990, and those were Drs. William Dedman of Camden, David Rodgers of Fayetteville, William Jones of Little Rock, and Ms. Peggy Cryer of the AMS staff.
 - d. Reviewed a letter from Dr. Pirnique in El Dorado pertaining to information sent out from Medicare pertaining to codes. They suggested Ken LaMastus write a letter asking the Medicare carrier, Blue Cross Blue Shield and Medicaid, to please include in all mailouts not only the code number but also a description of the code or procedure.

- e. Reviewed a letter from National Medical Rentals. It appeared the Committee was in sympathy of the problem associated with "hassle factor" in trying to get medical equipment to Medicare patients and asked that a letter be written in support of their concerns.
 - f. Received information on Channel 7's Health Expo and decided the Medical Society should not participate.
 - g. Reviewed a copy of the letter from the Arkansas Osteopathic Association concerning their nominating three osteopaths as possible consideration to be appointed to the Arkansas State Medical Board.
 - h. Decided not to join the U.S. Chamber of Commerce this year.
 - i. Discussed lab inspections. The program is required by federal law and decided to support the Arkansas Department of Health encouraging them to obtain the contract to do the inspections of physicians' offices in Arkansas.
 - j. Dr. Weber discussed what appears to be down-coding by Medicare on services provided by physicians pertaining to coronary care intensive care units.
3. Approved the minutes of the February 16, 1990, Executive Committee conference call as follows:
 - a. Recommended that the Society write a letter supporting Dr. Joycelyn Elders, director of the Arkansas Department of Health, for her nomination to receive an award from the AMA Adolescent Health Congress. The award will be for her work in the public service sector.
 - b. Reviewed information from Governor Bill Clinton's office pertaining to recommendations to the National Governor's Conference pertaining to various forms of national health insurance. The Committee recommended that we obtain the information from the AMA that was discussed at the December 1989 House of Delegates meeting and forward that to the Governor.
 - c. The Executive Committee approved travel to Alabama for Mr. Ken LaMastus to attend the CEO Conference.
 - d. Approved an educational program for Ms. Peggy Cryer sponsored by Dale Carnegie.
 - e. Mr. Ken LaMastus recommended that other members of the management staff attend this program with no more than one per year to attend.
 4. Reviewed information from Mr. David Wroten that Ms. Gierach had received a plaque from the AMA for the AMA Membership Outreach Program and expressed her appreciation to the Society for paying her expenses to the AMA meeting. Mr. Wroten reported that \$1,500 has been received to help defray expenses

- of the medical student representative at the next two AMA meetings.
5. Received a report from Joe Martindale, M.D. on the activities of the Physicians' Health Committee. Agreed to contract with a social worker for \$7,500 per year for assistance with everyday work relating to contacts, follow-ups, and correspondence for the Physicians' Health Committee. Funds was donated by St. Paul Insurance Company. Changed the title of the chairman of the Physicians' Health Committee to "Director". The social worker will be the executive director.
 6. Received a report from Mrs. J. Larry Lawson, president of the AMS Auxiliary, on the success of Phase I of the DWI Video Contest and procedures for Phase II.
 7. Received a report from A. E. Andrews on the proceedings of the AMA interim meeting. Dr. Andrews commended William Jones, M.D. for his help in amending the report on AIDS.
 8. Received a report from David Rogers, M.D. on the AMA Leadership Conference.
 9. Approved the changes made in Goal 4, of the Long Range Planning Committee, "Improve the Organizational Strength and Effectiveness of the AMS." A.3. reads as follows: "Members would serve for 2 year terms with a maximum of 3 consecutive terms. Terms will be staggered so that members from even-numbered districts will be appointed in even-numbered years and members from odd-numbered districts appointed in odd-numbered years." Approved the name change of the Arkansas Medical Society's Political Action Committee from AMS-PAC to MED-PAC.
 10. Received a report from Charles Rodgers, M.D. on a meeting with the Arkansas congressional delegation.
 11. Received a report from James Kolb, M.D. on the Senior Citizen Liaison Committee meeting held with representatives from the AARP. It was agreed to meet regularly and to implement the following goals: 1) Equitable reimbursements for medical services in Arkansas for Medicare, 2) No appropriations cut in Medicare by Congress in 1991 as proposed by the president's budget, and 3) to develop a speakers' bureau in opposition to mandatory assignments.
 12. Warren Douglas, M.D. presented the changes being proposed by the Constitution and Bylaws Committee that will be referred to the 1990 House of Delegates.
 13. Approved the position paper "Financial Policy of the Arkansas Medical Society". Tabled the position paper on MEFFA until its chairman could address the Council.
 14. Received an update from Lloyd Langston, M.D. on the Arkansas Health Care Access Foundation. The program is recognized nationally as successful and a leader in its field.
 15. Received a report from William Jones, M.D. on the activities of the AIDS Committee.
 16. Received information from Mr. David Wroten that the AMS was instrumental in helping medical students from the UAMS obtain a mannequin to be used in teaching CPR. The mannequin was obtained through a grant from the National Automobile Dealers' Association and the Arkansas Automobile Dealers' Association.
 17. Received a report from Morton Wilson, M.D. on the Arkansas Foundation for Medical Care. David Busby, medical director of the Foundation, also addressed the Council.
 18. Received a report from Mike Mitchell on the workers' compensation lawsuit and discussed a proposed amendment to the Arkansas Constitution by petition.
 19. Received a report from Merrill Osborne, M.D., that further information would be needed before a decision could be reached on the issue of presidential compensation.
 20. Appointed Steve Schoettle, M.D., of West Memphis, to the Young Physicians Committee.
 21. Chairman Lawson reported that a letter has been mailed to the Governor recommending Mike Moody, M.D. be reappointed to the Health Services Commission.
 22. Appointed T. E. Townsend, M.D. to fill the unexpired term of Joe Verser, M.D. as a delegate to the AMA. Dr. Townsend's term will expire December 31, 1990.
- The Council met August 5, 1990, at the Pleasant Valley Country Club in Little Rock and the following business was transacted:
1. Re-elected J. Larry Lawson, M.D. as chairman of the Council.
 2. Approved the minutes of the May 3-5, 1990 Council meetings as printed in the June 1990 issue of *The Journal of the Arkansas Medical Society*.
 3. Approved the minutes of the June 27, 1990 Executive Committee meeting as follows:
 - a. Discussed making information about delays in Medicaid claims available to Mr. Sheffield Nelson. Mr. LaMastus had some information documenting the percentage of claims that are not paid in a reasonable amount of time.
 - b. Approved out-of-state travel for two to attend the American Society of Association Executives meeting in Baltimore.
 4. Received an update from David Rogers, M.D. on the activities of the Committee on Smoking and Tobacco Products. The committee's goals which included a smoke-free society in the year 2000 was discussed.
 5. Received a report from Mrs. David Williams, president of the AMS Auxiliary, on her 1990-91 theme, "Targeting Volunteerism and Building Community Partnerships" which outlines four target areas —

health, legislation, AMA-ERF, and membership.

6. Received a report from Linda Markland, M.D., on the accomplishments of the AIDS Committee and discussed plans for the 1991 seminar.
7. Received a report from Nancy Kintzel, AMA Field Representative, on the AMA's "Health Access America" plan. The Council voted to: 1) go on record endorsing the plan concept and principles; 2) appoint a committee to study the plan and detail the provision, and 3) report their findings to the House of Delegates.
8. Received a report from Morton Wilson, M.D. on the Arkansas Foundation for Medical Care task force that works with small rural hospitals in financial difficulty. Received a report from David Busby on upcoming national PRO legislation.
9. Received a report from Payton Kolb, M.D. on the AMA annual meeting.
10. Received a financial report and evaluation summary from Glen Baker, M.D. on the 1990 Annual Session.
11. Approved changing the AMS Pension Plan to a more standardized form approved by the IRS. This would allow for a faster approval of amendments to the plan but would not affect the terms or benefits of the present pension plan.
12. Received a membership report from Mr. Ken LaMastus.
13. Approved the Budget Committee's recommendation to contribute an additional \$500 to the AMS Auxiliary DWI campaign.
14. Approved the purchase of two fax machines for the president and chairman of the council to use during their term in office.
15. Approved the following motion made by John Crenshaw, M.D.: "As the newly selected chairman of the MSRC, I have the opportunity and responsibility of selecting the vice chairman. I believe that the vice chairman should also be the chairman-elect. After I have served several years as chairman, if the vice chairman is conscientious, attentive and agreeable, he should be selected as chairman. Consequently, I believe the Council should have some influence over my selection. After due consideration, including discussion with representatives of Blue Cross Blue Shield, I propose Bill Allen of Little Rock as vice chairman of the MSRC."
16. The appeal of the workers' compensation lawsuit, Coleman vs. Holiday Inn was successful.
17. Received an update from I. Dodd Wilson, M.D. on UAMS students and school testing data.

The Council met October 28, 1990, at the Pine Bluff Convention Center and the following business was transacted:

1. Approved the minutes of the August 5, 1990, Council meeting with the following change - Item #13, last sentence to read, "Dr. Jones also requested that there

be an official document on file from the Pension Plan Board of Trustees indicating the reason for the change".

2. Approved the minutes of the August 22, 1990, Executive Committee as follows:
 - a. Approval was given for individuals to review the Mississippi Medical Association's self-insured health care plan.
 - b. Approved sending an invitation to Governor Bill Clinton as co-chair of the National Governors Association to speak about the work of his subcommittee.
 - c. Reviewed a request to endorse an amendment to the constitution on the Usury Rate Law in Arkansas. It was the decision of the Executive Committee to notify our members to review carefully the issues involved with the changes in the Usury Laws.
 - d. Discussed the letter from William E. Golden, M.D. pertaining to the Medical Center's program and it receiving a Robert Wood Johnson Foundation Grant to research quality assurance.
 - e. Discussed sending a representative to the CME Conference in Chicago. The decision was made to send a physician representing the Society only on request of the chairman.
 - f. Briefly discussed appointing a committee to look at the AMA's Health Access America National Health Insurance program. No appointments were made at this time.
3. The minutes of the September 26, 1990, Executive Committee meeting were approved as follows:
 - a. Dr. Baker reported on a visit with the Mississippi Medical Association.
 - b. Mr. Ken LaMastus reported on the planning of the Physicians' Health Committee to raise funds for a part-time medical doctor director of the program. The plan is to seek funding from the Arkansas Medical Society, the State Medical Board, malpractice insurance carriers, and a letter requesting voluntary contributions by physicians. Dr. Martindale would be put on salary with funds available to hire a part-time secretary. It was reported that almost all states now have at least a part-time physician to work with. The physician is under the jurisdiction of the Physicians' Health Committee.
 - c. Approved out-of-state travel for Ken LaMastus to attend a seminar in San Antonio, Texas, on non-dues income sponsored by the American Association of Medical Society Executives.
 - d. Gave approval for Mrs. Stephanie Percefull to attend a Journal conference sponsored by Sandoz in Boston.
 - e. Heard a report from George Warren, M.D. concerning a trip to Washington, DC, to meet

- with HCFA officials concerning the CLIA regulations.
- f. Reviewed a 15-minute video tape of the ABC T.V. program "Prime Time Live" concerning HCFA Inspector General Richard Kusserow. The Executive Committee recommended that the Arkansas Medical Society join the American Medical Association in requesting President George Bush to ask for the resignation of Mr. Kusserow.
 4. Approved the budget of the Physicians' Health Committee. The budget includes funding of a part-time position for a medical director and office. Joe Martindale, M.D. will serve as the medical director.
 5. Considered appointing an ad hoc committee to study the Physicians' Health Committee's projected needs over the next five years. Should the position of the director become a full-time position, funding would need to be established.
 6. Approved a request that the Society staff write physicians insured through St. Paul Insurance Company explaining their option to support the Physicians' Health Committee. By agreeing to contribute, their yearly refund check would be used as a committee funding source.
 7. Approved the new prototype pension plan.
 8. Received a report from Mr. Mike Mitchell regarding billing problems with Electronic Data Systems (EDS) and outlined the Society's options in dealing with these problems.
 9. Agreed to go on record stating that the Annual Session should be held in-state if appropriate sites can be found.
 10. Received a report from William Jones, M.D. on the activities of the AIDS Committee and recent correspondence with the AMA concerning AIDS.
 11. Discussed information on the PRO as received from Morton Wilson, M.D., chairman of the board of directors, Arkansas Foundation for Medical Care.
 12. Received a report from David Rogers, M.D. regarding the legislative targets of the Smoking and Tobacco Products Committee. The seminar instructing physicians as to "How to Help Your Patients Stop Smoking" is scheduled December 8th.
 13. Approved a request that the Society staff write letters of appreciation to the Jefferson County Regional Medical Center, the Jefferson County Medical Society, and the Pine Bluff Visitors Bureau for sponsoring the Saturday evening reception, symphony, and hospitality during the fall meeting.
 14. Received a report on the meeting on CLIA Laboratories held in Washington, DC.
 15. Received an update from Michael Moody, M.D. on the Certified Rural Health Clinics.
 16. Received a report from Mrs. Larry Lawson, chairman of the AMS Auxiliary/DWI Committee, on the success

of their Public Service Announcement contest.

17. Approved the following committee appointments: Budget Committee - Morton C. Wilson, M.D. of Fort Smith; and Physicians' Health Committee - Donald G. Browning, M.D. of Little Rock.
18. Entered into Executive Session to discuss the 1991 budget.

Fifth Councilor District

Wayne G. Elliott, M.D., Councilor _____

The Fifth Councilor District met on January 16, 1991, at the El Dorado Country Club. There was a nice turn out of 67 members to hear Dr. Terry Yamauchi, director of the Arkansas Department of Health and Human Services. We heard his novel method of increasing federal reimbursement to the state by imposing an excise tax on the state portion of Medicaid payments to physicians, hospitals, and nursing homes.

Dr. Bill Dedman of Camden was elected president of the Fifth Councilor District and Dr. Wayne Elliott was re-elected as Councilor.

Eighth Councilor District

Pulaski County Medical Society
Charles W. Logan, M.D., Councilor
James M. Parker, M.D., President _____

The Eighth Councilor District (Pulaski County Medical Society) engaged in numerous activities during 1990. A brief summary of the most significant of these is presented below.

The Society held two membership meetings; one featured Terry Yamauchi, M.D., who discussed the Medicaid situation in Arkansas, and the other one featured J. David Busby, M.D., who discussed various changes anticipated in the work of peer review organizations (PROs).

Letters were written to North Little Rock Mayor Patrick Henry Hayes, Little Rock Mayor Buddy Villines, Little Rock City Manager Tom Dalton, and Prosecuting Attorney Chris Piazza urging them to support the inclusion of a staffed infirmary in the soon to be constructed regional jail.

Letters were also written to U. S. Representatives Alexander, Anthony, Robinson, and Hammerschmidt asking that they support H.R. 4475, the "Medicare Physician Regulation Relief Amendments of 1990".

The Society successfully nominated M. Joycelyn Elders, M.D., to receive the Dr. Nathan Davis Award from the American Medical Association.

A \$5,400.00 scholarship was awarded to a freshman at the University of Arkansas College of Medicine.

Camp expenses for two children to attend Med-Camps

at Camp Aldersgate was underwritten (\$480.00).

A discount auto purchase plan was initiated whereby Society members may purchase new or used cars at discounted prices.

Additionally, the Society continued its administrative support of the Senior Physicians of Arkansas organization.

Tenth Councilor District

Morton C. Wilson, M. D., Councilor _____

The year 1990 proved to be a very active one for the Tenth Councilor District. Mr. Lynn Zeno, director of Governmental Affairs for the Arkansas Medical Society, addressed a combined meeting of the Sebastian County Medical Society and Auxiliary in January. He spoke about the political issues involving organized medicine and stressed the need to stay active politically for both physicians and spouses.

Dr. J. David Busby, medical director of the Arkansas Foundation for Medical Care, reported at the March meeting on the recommendations of the Pepper Commission.

Under the sponsorship of Drs. Calvin Bradford and Robert Hughes, a resolution was sent from the Sebastian County Medical Society urging our U. S. Representatives to support H.R. 4475 (the Medicare Physician Regulation Relief Amendment of 1990).

Dr. Paul Wills organized a Pre-Medical Education Committee to interest young students in the area in pursuing a career in medicine.

The October meeting was a special joint legislative meeting with the local state senators and representatives discussing mutual concerns. This meeting was also attended by Lynn Zeno and David Wroten from the Arkansas Medical Society.

Dr. David Rogers of Fayetteville was the featured speaker at the November meeting. He stressed the importance of political involvement in today's medicine and reviewed the changes that have taken place in the Arkansas Medical Society and its involvement in governmental affairs.

Report of the Executive Vice President

Ken LaMastus, CAE _____

In the past year, the Society has been involved in an increasing number of plans and programs representing physicians. The greatest problems facing medicine in Arkansas and the nation continue to be those related to the rising cost of health care. Many of the issues, in one way or another, evolve around efforts of cost containment, either from business or state and federal governments.

In an effort to assist people who may not be able to

afford the cost of health care, the Arkansas Health Care Access Foundation which was established by the Arkansas Medical Society, has provided some help. The foundation completed its first year of operation in September. Approximately 900 physicians in the state volunteered their medical services. The program encompasses almost 1,400 total volunteers from various groups or organizations including physicians, hospitals, dentists, pharmacists, and home health agencies along with assistance from the Arkansas Department of Human Services. A report on this program by W. Ray Jouett, M.D., president of the Foundation, is printed elsewhere in this issue of *The Journal*.

The volunteer participation of Arkansas physicians and other health care professionals demonstrates the caring we have for people who may not have the ability to pay for health care. All volunteers in this program should be complimented for their dedication.

The AMS budget for 1991 includes funding for the Physicians' Health Care Committee. This represents the first time ever the Society has made a financial commitment to helping physicians who have a chemical dependence problem. Joe Martindale, M.D., of Benton, is director of the Physicians' Health Committee. The Physicians' Health Committee budget provides for a part-time salaried director and office. Arkansas now joins most other states in providing this type of service to physicians of their state. The funding for this program came from a variety of sources including the AMS, contributions by professional liability insurance companies in Arkansas, donations from physicians throughout the state, and an anticipated contribution from the Arkansas State Medical Board. All of us should thank Dr. Martindale and the members of the committee for their efforts in being of assistance to physicians across the state who need professional help.

Approximately four years ago, the legislature passed a law giving the Workers' Compensation Commission authority to develop a fee schedule. Over the last few months, the staff of the AMS and a special committee appointed by the Society president has worked with the Arkansas Workers' Compensation Commission, at their request, to develop a fee system acceptable both to physicians and the Workers' Compensation Commission. Such a fee schedule would be tremendous help to the Commission in dealing with over one hundred insurance companies that provides this type of insurance coverage in the state. We appreciate the Commission's request for our assistance on this project.

There was a large amount of activity between the AMS and our congressional delegation. Several trips were made to Washington to meet with our delegation and the AMS played an important role in delaying, and hopefully, changing regulations pertaining to physician office laboratories.

It is an honor to have Mr. Lynn Zeno, our director of Governmental Affairs, selected to serve on a special AMA committee to provide liaison between the states and the

AMA office in Washington.

The 1991 session of the Arkansas General Assembly may provide the most help ever to the Medicaid program in Arkansas. Efforts to pass the provider tax bill should provide significant improvements in the level of payment to physicians and other providers of health care services through the Medicaid program. If this plan is successful, the payment level under Medicaid should far exceed that of Medicare and should approximate that of the Blue Cross Blue Shield rates.

The physicians in the state should thank the many physician members who have contributed their time and efforts to improve health care in this state. Special thanks should go to the Executive Committee who have spent untold hours in meetings and conference calls directing the activities of the AMS. Without the help of our leadership and volunteer physicians we would not have been able to complete this successful year representing medicine in Arkansas.

Governmental Affairs Council

Charles Rodgers, M.D., Chairman

The January issue of *The Journal of the Arkansas Medical Society* contained a eight page synopsis of the positions of the AMS regarding identified proposals to be addressed by the 78th Arkansas General Assembly. As this report is being written, we are at the midway point of the legislative session and our efforts have been very successful. AMS members are encouraged to continue to read and respond to the weekly Legislative Alert. A final report will be published at the conclusion of the session.

A special thanks should be extended to members of the Medical Society Auxiliary and to the members of the

Medical Group Managers Association. Their assistance and legislative contact programs have proven invaluable in our political efforts.

Federal Activities

The AMS, in cooperation with the AMA, continues to be active on the national level. Among the accomplishments for 1990-91 was the passage of the five-point physicians anti-hassle bill and the successful defeat/delay of the Clinical Laboratory Improvement Act of 1988. We are currently reviewing the reimbursement cuts implemented by the recently distributed MAAC charges and will be working closely with our U.S. Congressmen and Senators.

MED-PAC Update

Membership in our political action committee continues to improve. This past year witnessed the joining of our national and state PAC's into one fundraising unit called MED-PAC (Arkansas Medical Society Political Action Committee).

The first year for MED-PAC has been a very successful one, especially considering we only began soliciting contributions in July. Over 325 AMS members and spouses contributed to MED-PAC in 1991, exceeding our goal by 34%. Only six state medical associations in the U.S. attained a higher percentage increase than Arkansas.

Because of this increase, the AMS will receive a PAC membership award from the American Medical Association; our second in the last three years.

Although the percentage increases look good, we have a long way to go in sheer numbers. Less than 20% of all AMS members belong to MED-PAC. If we are to compete with other organizations in the legislative process this must increase to a minimum of 50%.

JOIN MED-PAC TODAY - BECOME PART OF THE SOLUTION!

MED-PAC is the political voice for Arkansas physicians supporting political candidates who best represent our concerns. Your participation in MED-PAC insures a continued, visible, and aggressive role in state and federal elections.

The AMS Governmental Affairs Council makes contributions based upon the following factors:

- *Recommendations of physicians contributing to MED-PAC.*
- *Opinions from local physicians and auxiliary members regarding the candidates qualifications.*
- *An incumbent's voting record and past support of medical legislation.*
- *Statistical analysis of previous election returns, political polls, and other factors assessing a candidate's electability are often considered, particularly in open seats.*

For more information, call 1-800-542-1058 or 224-8967 (in Little Rock), or write Arkansas Medical Society, P.O. Box 5776, Little Rock, Arkansas 72215-5776.

1990 Contributors to the AMS

Arkansas

Noble B. Daniel
Jerry D. Morgan
Carl Northcutt
* Hoy B. Speer Jr.
* Marolyn Speer
Dennis Yelvington

Baxter

Daniel P. Chock
Robert L. Kerr
Mrs. Robert L. Kerr
Thomas E. Knox
Peter A. MacKercher
David H. Roberts
David T. Sward

Benton

W.M. Allen
Mario E. Costaldi
C. William Hof
Frank Panettiere
Richard N. Pearson
M.C. Reese
Douglas A. Treptow

Boone

* Carlton L. Chambers
Geoffrey Dunaway
Jean C. Gladden
Thomas R. Hoberock
* Charles R. Klepper
Robert Langston
Mrs. Robert Langston
C.A. Ledbetter
John T. Troupe
Don R. Vowell

Carroll

Oliver Wallace

Chicot

* John P. Burge

Cleburne

J. Warren Murry
Jerry L. Thomas

Columbia

John E. Alexander Jr.

Conway

Keith M. Lipsmeyer

Craighead/Poinsett

Sylvan Bartlett
Ronald J. Blachly
J.C. Cook
Ben J. Cranfill
Glenn E. Dickson
Ernest L. Hogue
Michael L. Isaacson
R. Duke Jennings
Mrs. Kenneth B. Jones
H.J. Jordan
Henry W. Keisker
* Robert J. Landry
Robert Lassonde
Larry E. Mahon
Steven M. Moore
* Lovard M. Peacock
Herbert H. Price III
James Robinette
Ladd Scriber
W.T. Shanlever
Joe H. Stallings Jr.
Mrs. Joe H. Stallings
Joseph F. Tepley
Phillip M. Utley
* Don B. Vollman Jr.
Joe T. Wilson
John Woloszyn

Crawford

R.W. Ross
D. Bart Sills

Crittenden

* G. Edward Bryant
Edgar Scott Ferguson
Samuel G. Meredith
Steve P. Schoettle
Mrs. Steve P. Schoettle

Dallas

* Don G. Howard

Desha

Peter Go

Drew

A.K. Busby
Ralph M. Maxwell
Paul A. Wallick

Garland

Mrs. Lee G. Atherton

Robert V. Borg
Ronald J. Bracken
John H. Brunner
James F. Burton
Richard W. Dunn
W. Martin Eisele
* Allan C. Gocio
James E. Griffin
John L. Haggard
Edwin L. Harper
H. Joe Howe
Naomal S. Jayasundera
Dale Kincheloe
Robert W. Kleinhenz
Gopakumar Maruthur
Robert McCrary Jr.
B.V. Pai
Deno P. Pappas
Kenneth A. Siefert
Eugene Shelby
John B. Simpson
James Slezak
Bruce L. Smith
E.H. Stecker
Rhett Stecker
D.B. Stough
Richard A. Wyatt

Greene/Clay

* Roger E. Cagle
Asa A. Crow
Mrs. R. Lowell Hardcastle
Marion P. Hazzard
Len Kemp
* J. Larry Lawson
Richard O. Martin
John R. Sellars
C. Mack Shotts Jr.
Dwight Williams

Hempstead

Lloyd F. Mercer

Independence

J.D. Allen
Neema A. Garst
Dennis Luter
William J. Waldrip III

Jackson

Ramon E. Lopez
* Roland C. Reynolds

Jefferson

Keith G. Bennett
J.C. Campbell
John Crenshaw
Thomas S. Duckworth
Claude E. Fendley
Gary F. Frigon
* Robert R. Gullett
Francis M. Henderson
Shafqat Hussain
William J. James
Mary E. Jenkins
M.A. Khan
* Lloyd G. Langston
James A. Lindsey
David A. Lupo
John O. Lytle
Kenneth A. Martin
J. William Nuckolls
Reid Pierce
* Anna T. Ridling
Henry L. Rogers
Thomas E. Townsend

Lawrence

Robert D. Quevillon

Logan

Wayne P. Enns

Lonoke

Leslie Anderson

Miller

* A. E. Andrews
Stanley Collins
Leland Dodd
Mark Gabbie
F.E. Joyce
Larry Peebles
Jerry B. Stringfellow

Mississippi

Eldon Fairley
Joe V. Jones
R.F. Rhodes

Ouachita

Lawrence F. Braden
William D. Dedman
Robert L. Parkman Jr.

Political Action Committee (MED-PAC)

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Francis M. Patton

Pike

Phillip L. White

Polk

David D. Fried

Pope

Homer K. Beavers

Joe B. Curnpler Jr.

William W. Galloway

Ted Honghiran

* James M. Kolb Jr.

* Mrs. James M. Kolb

Andrew Monfee

Gerald A. Stolz

Stanley D. Teeter

* Finley Turner

Mrs. David Williams

Pulaski

James R. Adametz

Jeffrey Barber

David L. Barclay

Michael Bauer

Robert L. Berry

Raymond V. Biondo

William B. Bishop

W. Scott Bowen

Kelsy J. Caplinger III

Jerry Chapman

Richard B. Clark

Ernest C. Clifton

Howard Cockrill

Joe B. Colclasure

J.B. Cross

Philip J. Deer III

D. Bud Dickson

Warren M. Douglas

Rex M. Easter

* Jim English

Thomas M. Fletcher

G. Thomas Frazier

William E. Golden

C. Don Greenway

* James L. Hagler

Herbert L. Hahn

T. Stuart Harris

Richard Hayes

Harold H. Hedges

Richard Y. Henry

M. Bruce Johnson

* William N. Jones

R.A. Jordan

William F. Joseph

W. Ray Jouett

Mrs. W. Ray Jouett

* W. Payton Kolb

Mrs. W. Payton Kolb

Mrs. James F. Kyser

Mr. Ken LaMastus

Jay Lipke

* Steve Magie

Steve Marks

Peter M. Marvin

Hosea W. McAdoo Jr.

Richard E. McCarthy

Tom L. Meziere

Debra F. Morrison

Richard Nestrud

Joseph A. Norton

J. Mayne Parker

Clifton L. Parnell

Ruston Pierce

Norton Pope

Robert A. Porter Jr.

Robert C. Power

Carl J. Raque

* J. F. Redman

William H. Riley

* Charles H. Rodgers

F. Hampton Roy

William A. Runyan

Ben N. Saltzman

Jan W. Scruggs

C. Kemp Skokos

John G. Slater

Douglas F. Smart

Purcell Smith Jr.

Thomas J. Smith

J. Michael Stair

Alan R. Storeygard

J. Samir Sulieman

Berry Thompson

Mrs. Robert G. Valentine

T.M. Ward

James R. Weber

Mrs. James R. Weber

Samuel B. Welch

Frank M. Westerfield Jr.

Alonzo D. Williams

* C.D. Williams

Ronald N. Williams

Stephen Williamson

John Wilson

Thomas H. Wortham

Ruel N. Wright

Randolph

Hal S. Barre

John D. Smoot

Sebastian

Mike Berumen

* A. Calvin Bradford

Randall L. Carson

Robert L. Chester

Gary Felker

D. Bruce Glover

Adrian L. Herren

William A. Holman

Williams C. Holmes

J.T. Howell

Albert S. Koenig Jr.

Albert D. MacDade

Claude L. Martimbeau

Jimmy W. McChristian

R.C. Miller

Steve Nelson

Douglas Parker

Taylor A. Prewitt

Paul L. Raby

William H. Schemel

Robert L. Sherman

William M. Sherrill

J. Michael Standefer

* J. Earle White III

Mrs. Reem Zufari

Tri-County

* Michael Moody

Union

Bert Dougherty

Kenneth R. Duzan

Wayne G. Elliott

Richard C. Pillsbury

Allan S. Pirnique

* George W. Warren

Washington

Spenser D. Albright III

* James A. Arnold

James S. Beckman

David L. Brown

James F. Cherry

David R. Crittenden

Peter R. Heinzelmann

Mrs. Peter R. Heinzelmann

* Martha Hutson

Linda Markland

F.E. McEvoy

William McGowan

William C. Mills

* John R. Power

David L. Rogers

E. Mitchell Singleton

* John B. Weiss

Tom D. Whiting

White

* Daniel Davidson

Clark Fincher

* J. Garrett Kinley

* President's Club (contributed \$200.00 or more)



Arkansas Health Care Access Foundation, Inc.
W. Ray Jouett, M.D., Chairman _____

Arkansas Health Care Access Foundation completed its first full year of operations in September 1990. The Foundation was established to provide health care services for low income people who had no means of paying for health care. The services are provided by volunteer physicians, hospitals, pharmacies, dentists, and home health agencies with the certification of eligibility being provided by the Arkansas Department of Human Services.

The program was planned similar to the one that has been working in Kentucky for the last several years. The organizational work was done by the Arkansas Medical Society and involved work of the Arkansas Hospital Association, the Arkansas Pharmacists Association, the Arkansas Dental Association, the Arkansas Home Health Association, and the Arkansas Department of Human Services. When considering the range of services being offered, the Arkansas program is the most comprehensive volunteer network in the nation.

In the first year of operations, the Foundation certified as eligible, based upon recommendations from Human Services, over 9,000 Arkansas citizens. Of those 9,000 people, over 1,500 were referred for services. The majority of referrals were made to primary care physicians with most of those going to family and general practice physicians.

At its inception, the program was designed to have a limited amount of paperwork and therefore many of the statistics compiled are understated. Many of the referrals that went to a family physician and necessitated referral to a non-primary care provider were never reported to the Foundation. The same is true for many referrals to local hospitals. Referrals to hospitals especially, do not count the services that might have been provided by the hospital in general, as well as the pathologists, radiologists, and other speciality services.

Following the first year of application, a study was done by the Office of Business Research at Arkansas State University. The study was done in an attempt to have an objective review of the program and its impact on the people it has attempted to serve. Some of the information in the report included the fact that 9,600 people were determined eligible. A random sample of individuals utilizing the service showed that without AHCAF, 94% probably would not have received health care services and 96% of the survey respondents reported they would be likely to use the service again if the need arose. It is interesting to note that of the 9,600 found eligible, approximately 1,500 did utilize the service. Forty-two percent of the applicants were between the ages of 30 and 39; 66% of the applicants were white females; 22% were black females; and 12% were white male. The system was rarely used by black males.

The Board of the Foundation established the guidelines for eligibility as being those who were below the

federal poverty level but had no form of health insurance. The income eligibility ranged from \$6,279.96 for an individual and up to \$16,980 for a family of six.

Once eligibility was determined by the Department of Human Services, a copy of the form was provided to the individual making the application and a copy of it was forwarded to the Foundation. Once received by the Foundation the information was put in the computer. This was completed the day after the form was received at the Foundation. When an individual determined eligible needed service, they utilized the 800 number to the Foundation and were usually referred to a primary care physician for services. Virtually all provider groups involved agreed to provide some limited level of services. For physicians, this involved one office visit at no charge.

It was anticipated that if individuals needed other assistance, including a follow-up visit, many physicians would provide this level of service even though this was beyond their agreement. This proved to be accurate. Of those individuals surveyed, 48% were found to have received some type of medication, many times samples; 60% received lab work; and 40% received follow-up visits.

When the program was first planned there was concern, since this was a free program, that there would be a problem with over utilization. The sample survey tends to indicate that this was not the case. Of the 9,600 determined eligible, slightly over 1,500 utilized the service. Of those utilizing the service, 53% of those utilized the service only once, 23% twice, and only 23% used it more than two times. The most used by an individual was seven times.

The general geographical distribution of the applicants tends to fall with the population of Pulaski County physicians seeing about 29%, Jefferson County 5%, and Sebastian County 4%. The ten most populous counties accounted for 58% of the total referrals.

There were slightly less than 900 physicians who volunteered for the program. Of those, the average family physician saw six patients during the year with the gynecology and ophthalmology physicians seeing about the same number. Internists saw 3.3 patients, ophthalmologists averaging 2.5, and pediatrics 2. It should be noted that the Medicaid program covers a large number of children, proportionally more children than adults.

Because of the distribution of physicians volunteering for the program, it should be mentioned that physicians in St. Francis County saw an average of 13 patients each. In Montgomery County physicians saw about 11 patients a piece. There were only 8 of the 75 counties where no physician volunteers were available. Many physicians across the state are seeing patients at no charge or at a reduced charge. Many physicians did not volunteer because they felt like they were carrying a heavy load of people without the ability to pay prior to this program.

When this program was organized, we wanted to

prove that Arkansas physicians and others providing health care services and products care about their patients. We believe the study and success of the program demonstrates that Arkansas doctors and others do care about people who may not be able to afford needed services.

Medical Services Review Committee

John Crenshaw, M.D., Chairman _____

The Medical Services Review Committee (MSRC) insures the patients of Arkansas with a proper utilization review and quality assurance of selected cases of Blue Cross Blue Shield and Medicare claims.

During the past year, seven committee meetings were held, approximately 88 cases were reviewed, and personal appearances before the committee was made by three Arkansas physicians.

Other activities of the MSRC included meetings with the Workers' Compensation Commission. Through these meetings, better lines of communications with the Commission were established and now the Commission has a clearer understanding of our reimbursement process.

The position of vice chairman of the MSRC was expanded to chairman-elect at the recommendation of the MSRC Chairman and approval of the Council of the Arkansas Medical Society.

I would like to express my appreciation to all the members of the MSRC, Drs. Bob Benafield and Bill White, and the rest of the staff of Blue Cross Blue Shield for their hard work and support.

Task Force on Perinatal Care Access

William D. Dedman, M.D., Chairman _____

The Arkansas Medical Society Task Force on Perinatal Care Access corresponded with members of the Governor's appointed Perinatal Advisory Board and reviewed their annual report. After thorough review of

their report, the task force offered its full support and agreed to cooperate in any legislative or community efforts to expedite these recommendations. Governor Clinton was also notified of our support.

The Task Force met with Arkansas Department of Health personnel to discuss specific legislative issues to be presented in the general legislative session.

Agreement was made by all parties involved in perinatal care that we should work as a team to continue to improve perinatal health care in Arkansas.

Pension Plan Trustees

J. Floyd Kyser, M.D., Chairman _____

The Pension Plan Trustees had one conference call and one meeting in 1990.

Based upon the recommendation of our pension plan attorney, Mr. David Simmons, the pension plan was changed to a more standardized format making it more acceptable to the IRS.

Our Pension Plan, like many others, has been faced with requirements to make amendments each year in order to comply with IRS regulations. These changes have required on ongoing legal expense. The new plan is a "model" plan approved by the IRS which should reduce yearly legal work necessary to comply with new IRS regulations.

There were no changes in the dollar amount of contributions or employee benefits; only technical changes conforming to the model format.

Quarterly reports are received from Worthen Bank, the management company for the fund. AMS employees also receive an annual report listing their total benefits for the year.

I would like to thank the following members of the Board of Trustees: Drs. Joe H. Stallings, Thomas H. Hollis and James M. Kolb, and Mr. David Simmons for his work on revising the plan.



Physicians' Health Committee

Joe L. Martindale, M.D., Chairman

The Physicians' Health Committee has had a good year. Since 1987, approximately 30 physicians have entered our program; some who are currently being monitored and others who have successfully completed the program.

A part-time director has been funded, an executive committee established, and an associate director selected. A policy and procedures manual was developed and a new member was added to the committee.

This past year, the Committee helped establish two support groups and organized an Arkansas Chapter of the American Medical Society of Addictive Medicine.

A firm, good-working relationship has been established with the Arkansas State Medical Board and we have developed a relationship with the medical center. Efforts are being made to establish a chemical dependency curriculum at the medical center. In the future, the Committee will strive to become quite active in the educational process within our hospitals and in the Society. These changes will enable us to reach even more impaired physicians.

Success with our colleagues depends upon reporting suspected impairments and we need your help with this. We hope to teach all of our physicians and significant others how to do this.

Physicians' Health Committee Budget for 1991

<i>Income</i>	<i>Estimated</i>
Arkansas Medical Society	\$10,000.00
Arkansas State Medical Board	10,000.00
St. Paul Insurance*	22,000.00
Other Insurance Companies	10,000.00
Contributions	<u>5,000.00</u>
Total	\$57,000.00
 <i>Expenses</i>	 \$35,000.00
Contract Medical Director	
(secretarial support included)	500.00
Computer Software	1,200.00
Office Equipment	1,000.00
Supplies & Postage	3,000.00
Telephone & Answering Service	5,000.00
Travel - Medical Director	<u>1,000.00</u>
Miscellaneous Expenses	\$46,700.00
Total	

* Received \$27,000.00 from St. Paul; approximately \$22,000.00 remaining.

Crittenden County Medical Society

Steve P. Schoettle, M.D., President

Thankfully, 1990 has been a fairly quiet and uneventful year for the Crittenden County Medical Society. As with many other physicians in the eastern Arkansas area, we were geared up to respond to the predicted earthquake in early December. Thankfully, this was not needed at the present time. Together with our local hospitals, we have devised multiple emergency plans for treatment and evacuation of injuries, should an earthquake occur. These plans will be implemented, of course, if our hospital is still standing. Otherwise, we have had close contact with the Trauma Center in Memphis and arranged for medical evacuation if need be.

We have continued our close contact with our legislators, including a new representative and senator from our district. We have continued our annual barbecue in their honor, and it has been highly successful in them getting to know us and us getting to know them. We feel that our new representative from Marianna and our new senator from Marked Tree were pleased to have been honored in this way, and hopefully, it opened communication channels between ourselves and them. We hope that these activities and communication will continue to be helpful as we approach the upcoming legislative session.

Sebastian County Medical Society

Taylor Prewitt, M.D., President

In an effort to combat the lack of interest in medicine as a career, the Sebastian County Medical Society has formed a Pre-Med Education Committee with Dr. Paul Wills as its chairman, to stimulate more student interest in the medical profession.

The Sebastian County Medical Society and the Fort Smith public schools have joined together through the Partners in Education program in this effort. The Society contributed \$2,000 to the Fort Smith School District to be used to help sponsor science fairs and to fund summer scholarships for science teachers to attend conferences that increase their awareness of medicine as a career choice for students. The Society has established a library at secondary schools with videos encouraging interest in the choice of a health career and shelves at local libraries with a core of literary classics to promote the learning of ethics. Also, members of the Sebastian County Medical Society have agreed to make themselves available to talk to students who are interested in entering the health care field.

In October, the Sebastian County Medical Society held a special legislative meeting inviting all local legislators to participate in an open panel discussion.

The following are resolutions passed by the Sebastian County Medical Society.

The Sebastian County Medical Society urges its

U.S. Representatives to support and consider co-sponsoring H.R. 4475, "The Medicare Physician Regulation Relief Amendment of 1990," introduced by Representative J. Roy Rowland, M.D. (Democrat/Georgia).

This "anti-hassel" bill contains important Medicare reform which provides physician input and restricts some of the onerous power of HCFA.

Approved May 8, 1990

The Sebastian County Medical Society endorses a move to have Inspector General Richard Kusserow removed from office.

Approved December 11, 1990

Tri-County Medical Society

Lewis G. Allen, M.D., Secretary _____

The regular quarterly meeting of the Tri-County Medical Society was held December 19, 1990 at Salem.

The following members and guests were present: Dr. Thomas Benton, Dr. and Mrs. George Jackson, Dr. and Mrs. Jim Bozeman, Dr. and Mrs. Lewis Campos, Dr. and Mrs. Carl Arnold, Dr. Lewis Allen, Dr. and Mrs. Meryl Grasse, Dr. David Ducker, Dr. and Mrs. Donald Wright, and Dr. and Mrs. Michael Moody. Guests present were Dr. Charles Tucker, Lynn Zeno, Chris Finkbeiner, Dr. and Mrs. Lawrence Heise, Mike Wright of the Pharmaceutical Marketing Association, and Debbie Hayes, Rorer Laboratories.

Following dinner, graciously served by the Fulton County ladies, Lynn Zeno discussed the importance of physicians participating in the political process.

The business meeting was then convened and the report of the September 12, 1990 meeting was read. The treasurer's report stated a bank balance of \$1,604.32. The Society approved the expenditure of \$182.25 to cover the meal at the September 12, 1990 meeting and a \$35.00 expenditure for hall rent at the same meeting. Approved reimbursement to the secretary of \$52.50 for postage and secretarial services since September 1988.

The proposed slate of officers for 1991 was submitted by the trustees and approved by unanimous vote. Dr. Carl Arnold was re-elected to another three-year term as trustee. Trustees and officers for 1991 are:

Trustees

Harry Kearns, one year
Robert Lane, two years
Carl Arnold, three years (re-elected)

Officers

President: George Jackson
President-elect: Donald Wright
Secretary/Treasurer: Lewis Allen

Delegate: Meryl Grasse

Alternate Delegate: Tom Benton

The Society is grateful for the courtesy of Rorer Pharmaceutical and the Pharmaceutical Marketing Association by providing the cost of the meal.

The next meeting is to be March 13, 1991 (Meisenheimer Memorial) and will be under the direction of the Izard County members.

The meeting was adjourned at 9:15 p.m.

Medical Education Foundation for Arkansas (MEFFA)

W. Martin Eisele, M.D., President _____

The Medical Education Foundation for Arkansas is a private, non-profit foundation that was organized by the Arkansas Medical Society specifically to provide assistance to UAMS in the areas of medical education. It was organized in 1959 and \$5.00 of the dues of each regular member of the Society is contributed to the fund each year.

The other members of the Foundation Board are Dr. Jean Gladden, Dr. Amail Chudy, and Dr. Ray Jouett. Ex-officio members with voting power are Dr. Bill Jones, AMS president, Dr. George Warren, president-elect, Dr. James Weber, immediate past president, and Dr. I. Dodd Wilson, dean of UAMS. The Foundation Board makes decisions about such matters as how the funds are spent and the investment strategy for the investments of reserve funds. The Board has adopted the strategy of investing in only government-guaranteed securities or those insured under the FDIC. All investments are fixed-income securities and the Board policy has been to attempt to accumulate funds over time to allow for the growth of the Foundation.

In 1990 the MEFFA Board met on two occasions to discuss plans for providing assistance to UAMS. The primary focus has been upon payment for outside speakers who would have otherwise not been available to UAMS students.

The Board has discussed its focus on funding and has met with Dr. I. Dodd Wilson to discuss various projects or means by which the Foundation could be of assistance.

Efforts have been made at UAMS to more widely publicize the fact that some of the speakers who are appearing are funded with the Foundation's help.

The MEFFA Board reported to the Council in 1990 and discussed the activities of the Foundation. The Foundation is audited each year by an independent CPA firm.

Following meetings with the Council, the MEFFA Board determined the need to further educate all physicians about the existence and functions of MEFFA. The Arkansas Medical Society, through its publications and

meetings, is working to more widely publicize the Foundation.

Listed below are the speakers supported by MEFFA last year:

Judith Domer, Ph.D., professor of Microbiology,
Tulane University

Kenneth Ludmerer, M.D., Washington University

Lerner B. Hinshaw, Ph.D., Oklahoma Medical
Research Foundation

Margaret L. Kirby, Ph.D., professor of Anatomy,
Medical College of Georgia

Cardon D. Schneck, M.D., Ph.D., professor of Anat-
omy, Temple University School of Medicine

Malcom Brenner, Ph.D., professor of Pediatrics, Uni-
versity of Tennessee

Magdalena Eisinger, M.D., Sloan Kettering Institute,
New York

James H. Woods, M.D., professor of Pharmacology,
University of Michigan

Alf Nachemson, M.D., Othenberg University, Sweden

Rita Teele, M.D., associate professor of Radiology,
Boston Childrens' Hospital

University of Arkansas College of Medicine

I. Dodd Wilson, M.D., Dean

The College of Medicine's programs grew substantially during 1990. Many new and excellent faculty members were recruited. The following four chairman and three major division directors joined the faculty during the year:

Alan Elbein, Ph.D.

Department of Biochemistry & Molecular Biology

Geoffrey Goldsmith, M.D.

Department of Family & Community Medicine

E.F. "Bud" Klein, M.D.

Department of Anesthesiology

Gerald Quirk, M.D., Ph.D.

Department of Obstetrics & Gynecology

Division of Toxicology (Pharmacology)

Jack Hinson, Ph.D.

Division of Nephrology (Medicine)

Sudhir Shah, M.D.

Division of Transplantation Surgery

Beverly Ketel, M.D.

The Arkansas Cancer Research Center is the focus of a growing oncology research and education program.

Clinical programs at both Arkansas Children's Hospital and the University Hospital of Arkansas grew and improved during 1990. The McClellan Memorial VA Medical Center is among the largest in the country and is a real asset for provision of excellent medical care in Arkansas.

Education is the primary focus of the college. The Curriculum Committee finalized the proposal for a mandatory four week, third year family medicine clerkship which will begin in the fall of 1991. Plans to revise the Ethics course were also completed.

A number of positive educational changes have occurred. Freshman orientation has been substantially altered to make it more effective. Both the Department of Pharmacology and the Department of Internal Medicine have revamped their core courses. A computer for use by the students to access the AMA Freida program for residency selection, a copier solely for unlimited student use, and a computer bulletin board for student information and use have been added to the Dean's Office. There has been a rapidly growing interest by students in the courses offered by the Division of Medical Humanities. We continue to look at the teaching of lifelong learning skills. Recently the campus approved a 20-station computer teaching laboratory.

Beginning with this year's freshman class, the only pathway to licensure is through the National Board of Medical Examiners (NBME) test. The college makes teaching a high priority and feels that its educational programs are at least on a par with other American medical schools. The college has been disappointed in the scores of sophomore medical students on the NBME Part I examination. A systematic analysis of the data generated from the two classes that have taken the NBME exam has provided some interesting information. First, the FLEX exam is easier than the National Board exam. The level of preparation of our entering students, as assessed by the Medical College Aptitude Test (MCAT), is low when compared to the national norm. Certain demographic data such as age and marital status are associated with varying chances for success. While the admissions process does very well at identifying top students, it is not nearly as accurate at the bottom of the admissions list where some students are having great academic difficulty and others are doing quite well. We need to focus attention here. Recruitment efforts have been increased. There were 340 applications from Arkansas residents this year as opposed to just 225 three years ago.

To improve results on the NBME test, the college has implemented many new practices. The test policy has been revised to provide course examinations more similar to the NBME Part I. Administration of quizzes within courses, greater emphasis on review sessions, institution of a new intensive review course, identification of students with learning disabilities, and emphasis on group interactive learning have all begun. During the next year, we

will modify our prematriculation requirements, begin to provide courses to remedy educational deficiencies, and institute faculty teaching development programs. We are considering an intensive review of all mandated courses over a five to six year cycle in the college. This spring we will assign a faculty member to implement and coordinate all programs related to NBME test problems.

Our College of Medicine is second of the southern, traditionally white, state medical schools in its percentage of underrepresented minority medical students. We are supported by the Winthrop Rockefeller Foundation to conduct a Summer Science Program for 30 promising college minority students and are working with minority high school students through a research program funded by the National Institutes of Health.

The college has substantial needs for scholarships. We have increased the scholarship funding available from college and local resources from \$120,000 to over \$300,000 in three years, but are still unable to supply substantial four year scholarships to more than a few of our students. The total debt acquired by each medical school class is approaching \$5,000,000. Many of our students will repay more than \$200,000 to satisfy their loan obligations. We are especially appreciative of the work the State and County Medical Society Auxiliaries in supporting AMAERF. The AMAERF funds designated for student financial support are being used to build an endowment for medical school scholarships.

The college is very appreciative of the support that has been given by the Medical Education Foundation for Arkansas for its lectureship program. This year, ten outstanding lecturers have been invited to campus where they participate in student education. In addition, the funds from the AMAERF program designated for general use enhance the educational programs in the college.

We are building a stronger research program. The quest for greater knowledge will enhance the environment for medical education. Overall college expenditures for research from grants and contracts reported to the Association of American Medical Colleges in 1983-84 were \$5,405,335 compared to a total in 1989-90 which was \$14,389,849. The growth rate remains rapid.

In summary, overall the college is doing very well. It has growing strengths in education, research and clinical programs. It is working hard to provide strong educational experiences and to improve student performance, especially on the NBME examinations.

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Call the Society office for more information:
(501) 224-8967 or 1-800-542-1058

Report of the Constitution Revision Task Force Warren Douglas, M.D., Chairman

During last year's annual meeting, major revisions in the AMS Constitution and Bylaws were approved. Among those changes were limits on how many consecutive years a member could serve in the same AMS office. Councilors were given a maximum of four terms (8 years), while other offices and committees were limited to six years.

In the discussions that took place on the floor of the House of Delegates, two issues arose which our committee was asked to consider. These issues were time limits for delegates to the AMA and a possible exception to the councilor limit for the chairman.

In response, our committee has come forth with two amendments which will be considered at the 1991 AMS convention. These are printed at the end of this report.

In essence, the committee felt that a limit should exist for AMA delegates and alternates, but that an exception should be made for someone who is dynamic enough to obtain a position on an AMA council or committee.

In discussing whether to extend the eight year councilor limitation for the chairman, we took into consideration that one needs to have experience on the Council for a period of time before being chairman. Keeping that in mind, we agreed that the chairman should be held to the same six year limitation as are the other AMS officers. Therefore, we have proposed that the chairman be exempt from the eight year councilor limitation provided that they can only serve as chairman for up to six consecutive years. Conceivably, the person could be on the Council for 12 to 14 years.

Notice of these amendments has been given according to the requirements set forth in the new Bylaws which will be in effect at the time the reference committee meets in April.

The AMS Task Force on Constitutional Revision recommends the following amendments to the Bylaws:

Council Chairman (Chapter V, Section 6[A])

Add to current language...This limit shall not apply to the councilor who (1) is serving as chairman, and (2) is otherwise eligible to be re-elected chairman; provided no member shall serve as chairman more than six consecutive years.

AMA Delegates (Chapter V, Section 6[B])

Delegates and alternate delegates to the American Medical Association shall be elected in accordance with the Bylaws of that organization; provided no member shall serve for more than a combined total of 12 consecutive years. This limit shall not apply to any delegate or alternate delegate while serving in an elected or appointed position to an AMA council, committee, or board.

House of Delegates Approves New Constitution and Bylaws

On May 5, 1990, the Arkansas Medical Society passed major revisions in the Constitution and Bylaws. Current rules require that these revisions be published twice during the year and then voted on again at the 1991 Annual Session, before becoming effective. This is the second publication.

New language is identified by "italics"; language to be deleted is struck through. These revisions will be considered at the First Session of the House of Delegates on April 25, 1991.

Constitution and Bylaws of the Arkansas Medical Society

CONSTITUTION

ARTICLE I. Name of Society

The name of this organization shall be the Arkansas Medical Society.

ARTICLE II. Purposes of the Society

The purposes of this Society shall be:

1. To federate and bring into one compact organization the entire medical profession of the State of Arkansas and to unite with similar societies of other states to form the American Medical Association;
2. To extend medical knowledge and advance medical science;
3. To elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws;
4. To promote friendly intercourse among physicians;
5. To guard and foster the material interests of its members and to protect them against imposition;
6. To enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life; and
7. To maintain medical ethics and to secure compliance with the art and science of medical practice.

ARTICLE III. Component Societies

Component societies shall consist of those societies which hold charters from this Society as provided in the Bylaws.

ARTICLE IV. ~~Composition of the Society~~

Section 1. ~~Composition~~

~~This society shall consist of members, delegates and guests.~~

Section 2. ~~Members~~

~~The membership of this Society shall comprise all the members of its component societies.~~

Section 3. ~~Delegates~~

~~Delegates shall be those members who are elected or seated in accordance with the Constitution and Bylaws to represent their respective component societies in the House of Delegates of this Society.~~

Section 4. ~~Guests~~

~~Any distinguished physician not a resident of this State, who is a member of his own state society, may become a guest during any annual session on invitation of the officers of this Society, and shall be accorded the privilege of participating in all of the scientific work for this session.~~

ARTICLE IV. *Members (New)*

The Arkansas Medical Society is composed of individual members of its component societies and others as may be provided for in the Bylaws.

ARTICLE V. Sections and District Societies (Old Art. VII)

The House of Delegates may provide for a division of the ~~scientific~~ work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of ~~component societies: this Society.~~

ARTICLE ~~V~~. VI *House of Delegates*

The House of Delegates shall be the legislative body of the Society, and shall consist of (1) delegates elected by the component societies or seated by the House of Delegates to represent component societies as provided in the Bylaws; (2) the councilors, and (3) ex-officio, the President, First Vice President, President-elect, Speaker, Vice Speaker, Secretary, Treasurer, and past presidents of the Society; provided, however, that the ex-officio members shall have the power of voting on all subjects except the election of officers. (Trans. to Ch. IV, Sec. 6, Bylaws)

The House of Delegates shall be the legislative and policy-making body of the Society composed of members

elected by the component societies and others as provided in the Bylaws. The House of Delegates shall transact all business of the Society not otherwise provided for in this Constitution and Bylaws and shall elect the general officers except as may be provided in the Bylaws.

ARTICLE VI Council (Moved to ARTICLE VIII)

ARTICLE VII. General Officers (Prev. Art. IX)

The officers of this Society shall be a president, president-elect, ~~three vice presidents~~, *vice president*, Speaker of the House of Delegates, Vice Speaker of the House of Delegates, a secretary, a treasurer, an immediate past president, and councilors. Their qualifications and terms of office shall be as provided in the Bylaws.

ARTICLE VII. VIII Council (Sec. 2 & 3 moved to CH. VII)

Section 1. Duties

The Council shall be the executive body of the House of Delegates and between sessions of the House shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws. It shall constitute the Finance Committee of the House of Delegates.

Section 2. Composition

The Council shall consist of the councilors, the president, ~~first vice president~~, president-elect, secretary, treasurer, ~~and immediate past president~~, *and the Speaker of the House of Delegates. The Vice Speaker of the House of Delegates, and the Delegates and Alternate Delegates to the American Medical Association shall be members ex-officio without vote. The Speaker and Vice Speaker of the House of Delegates and the past presidents shall be members ex-officio without vote, except that the Immediate Past President shall have a vote.* There shall be two councilors from each district which has two hundred members or less. In districts where there are more than two hundred members, there shall be an additional councilor for each additional one hundred members. The councilors shall serve staggered terms of two years each. All councilors shall have equal voting privileges. A majority of the voting members shall constitute a quorum.

Section 3. Representation

Representation on the Council shall be based upon the enumeration of members in each councilor district in accordance with provisions of these Bylaws for representation in the House of Delegates.

Section 4 3. Executive Committee

The Chairman of the Council, the president, the president-elect, the secretary, *the treasurer*, and the immediate past president shall constitute the Executive Committee of the Council. The Chairman of the Council shall serve as Chairman of the Executive Committee. The Executive Committee shall have such powers and duties as provided in the Bylaws and as may be defined from time to time by resolution of the Council.

ARTICLE VIII. IX Sessions and Meetings

Section 1.

~~The Society shall hold an Annual Session, during which there shall be held daily general meetings, which shall be open to all registered members and guests.~~

Section 2.

~~The place and time for holding each Annual Session shall be decided by the Council.~~

The Society shall hold a meeting of the House of Delegates at least annually and at other times as deemed necessary or as provided in the Bylaws. The place and time for holding each meeting shall be determined by the Council.

ARTICLE X. Funds and Expenses, Dues and Assessments

Section 1.

~~Funds shall be raised by an equal per capita assessment on each component society except as provided in the Bylaws. The amount of the assessment shall be fixed by the House of Delegates on four-fifths vote of the delegates present.~~

Section 2.

~~Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. Funds may be appropriated by the House of Delegates to defray the expenses of the Society for publications, and for such other purposes as will promote the welfare of the profession. All resolutions appropriating funds must be referred to the Council before action is taken thereon.~~

Funds may be raised by annual dues, or assessments, on the members of the Society except as provided in the Bylaws. The amount of dues or assessments shall be fixed by the House of Delegates on four-fifths vote of the delegates present, provided that a written notice has been sent to all dues paying members at least 90 days prior to the House of Delegates meeting. Funds may also be raised from voluntary contributions, society publications and services. All resolutions appropriating funds must be referred to the Council before action is taken thereon.

ARTICLE XI. Referendum

Section 1.

~~A general meeting of the Society The House of Delegates may, by a two-thirds vote, of the members present, order a general referendum on any questions pending before the House of Delegates it, and when so ordered the House of Delegates shall submit such questions to the members of the Society, who may vote by mail or in person. If the members voting shall comprise a majority of all the members of the Society, a majority of such vote shall determine the question and be binding upon the House of Delegates.~~

Section 2.

~~The House of Delegates may, by a two-thirds vote of its own members, submit any questions before it to a general referendum, as provided in the preceding section;~~

and the result shall be binding upon the House of Delegates:

ARTICLE XII. The Seal

The Society shall have a common seal, with power to break, change or renew the same at pleasure, by action of the House of Delegates.

ARTICLE XIII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in a bulletin or journal of this Society, meeting of the House of Delegates, provided that the amendment shall have been mailed to all members at least 90 days prior to the meeting.

BYLAWS

CHAPTER I. Membership

~~Section 1. Membership in Component Societies~~

- ~~(A) Membership in this Society shall be by membership in one of its component societies.~~
- ~~(B) The name of a physician on the properly certified roster of members of a component society which has paid its annual assessment shall be prima facie evidence of membership in this Society.~~

Section 1. General Requirements for Membership

A person seeking application to this Society must fulfill at least one of the following requirements:

- (A) Possess the degree of Doctor of Medicine or Osteopathy AND hold a license to practice medicine and surgery issued by the Arkansas State Medical Board; (B) Are Intern/Residents serving in an approved training program in this state; or (C) Are Medical Students enrolled in an approved medical school in this state.

Any person when becoming a member shall agree to abide by the Constitution and Bylaws of this Society and by any changes which from time-to-time may be made. The member further agrees to abide by the Principles of Medical Ethics of the American Medical Association.

~~Section 2. Membership Classifications~~

Section 2. Membership Categories

Categories of membership are: A. Active; B. Active Direct; C. Life; D. Emeritus; E. Affiliate; F. Associate.

(A) Active Membership

The active membership of this Society shall be comprised of all the active members of its component societies. Only such person is eligible for active membership in a component society as possesses the degree of Doctor of Medicine or Doctor of Osteopathy and holds an unrevoked license to practice medicine and surgery issued by the Arkansas State Medical Board. The eligibil-

ity requirements set forth in the preceding sentences are not to apply, however, to the members of the specially chartered "Student and Intern and Resident Societies."

(A) Active

Active members are members of component societies who are entitled to exercise the rights of membership in their component society. A person eligible for Active membership shall become a member of this Society upon certification by the secretary of the component society to the Arkansas Medical Society Executive Vice President that the person meets the requirements for membership in Chapter I, Section 1, of these Bylaws. Intern/residents and medical students shall be entitled to the same rights and privileges accorded other members except that they shall not hold office or chair committees.

(B) Active Direct

Active Direct members are those who apply for membership in this Society directly rather than through a component society. Intern/residents and medical students shall not be eligible for this category.

- (1) Active Direct members are admitted to membership upon application to the Executive Vice President and after approval by the Executive Committee of the Arkansas Medical Society. When reviewing applicants for Direct membership, the Executive Committee shall establish that the applicant meets the requirements of membership as outlined in Chapter I, Section 1, of these Bylaws and may consider information pertaining to the character and ethics of the applicant. The Committee shall provide by rule for an appropriate hearing procedure to be provided to the applicant.

- (2) The Arkansas Medical Society shall immediately notify the secretary of each component society of the name and address of those applicants for Active Direct membership residing within its jurisdiction.

- (3) Objections to applicants for Active Direct membership must be received by the Executive Vice President within 30 days of receipt by the component society of the notification of application. Any objections will be referred to the Executive Committee of the Arkansas Medical Society for disposition.

- (4) Active Direct members shall have the right to vote, hold office, and all other privileges of membership in this Society.

(B) (C) Life Membership

A physician who has been an Active or Active Direct member of this Society for a period of ten

years and who has continuously been a member of organized medicine and has either (1) attained age seventy or (2) practiced forty-five years shall be eligible for life membership. ~~and, upon the recommendation of his component society, shall be granted such status by the House of Delegates. Such status shall be granted by the House of Delegates upon the recommendation of the members' component society or, in the case of an Active Direct member, the Executive Committee of the Arkansas Medical Society.~~ Life members shall have the right to vote, hold office, and all other privileges of membership in this Society.

(C) (D) Emeritus Membership

A physician who has been an *Active or Active Direct* member of this Society for a period of ten years and who has continuously been a member of organized medicine for less than forty-five years and who has fully retired from the practice of medicine shall be eligible for emeritus membership. ~~Such membership shall be granted by the House of Delegates upon the recommendation of the member's component society. Such status shall be granted by the House of Delegates upon the recommendation of the members' component society or, in the case of an Active Direct member, the Executive Committee of the Arkansas Medical Society.~~ Emeritus members shall have the right to vote, hold office, and all other privileges of membership in this Society. *Emeritus members shall be entitled to all privileges of this Society except that they shall not hold office.*

(D) (E) Affiliate Membership

An *Active or Active Direct* member in good standing ~~in his component society~~ may be granted affiliate membership where one or more of the following conditions exists: physical or other disability of a character preventing the practice of medicine, a serious and prolonged illness, financial reverses, or *service in the armed forces of the United States, not as a career officer.* Affiliate membership shall be on an annual basis only and ~~a member~~ must be recommended each year for such special status by ~~his the member's component society or, if an Active Direct member, the Arkansas Medical Society Executive Committee~~ following a review and reassessment of ~~his the~~ particular situation. An Affiliate members shall enjoy full membership privileges except that ~~he~~ they shall not have the right to vote or hold office.

(E) Military Members

An active member in good standing in his component society who enters the service of the armed forces of the United States, not as a career

officer, may be classified as a military member, and carried on the roll of his component society as such.

~~A physician entering service of the armed forces of the United States, not as a career officer, upon completion of internship or residency training shall be eligible for military membership upon the request of a component society.~~

Military members shall enjoy full membership privileges except that they shall not have the right to vote or hold office.

(F) Associate Members

Physicians who are licensed to practice medicine and surgery in this State as well as an adjacent state and are engaged in the delivery of health services in both states may become associate members of this Society provided they are active members of the state medical association in the adjoining state. Associate members may vote as provided in this Constitution and Bylaws and may serve on all committees, but shall not hold office.

(G) Intern and Resident Members

Physicians licensed to practice medicine and surgery in this State who are engaged in filling intern or residency appointments in approved hospitals shall be eligible for membership in this Society. ~~Such membership shall end with termination of this status. Such members shall enjoy the rights and privileges accorded active members except that they shall not hold office or chair committees.~~

(H) Student Members

Students enrolled in an approved medical school shall be eligible for student membership in this Society. ~~Student members shall enjoy the rights and privileges accorded active members except that they shall not hold office or chair committees.~~

Section 3. Dues Exemption

- (A) Life, emeritus, affiliate, ~~military, intern and~~ intern/resident, and student members shall be exempt from the payment of dues and assessments.
- (B) Associate members shall pay one-half of all dues and assessments.
- (C) New active members of the Society entering practice in Arkansas shall be exempt from dues from the date of entry into practice until the next regular dues period. The following year, the dues assessment shall be at one-half the total amount. Thereafter, full dues are payable.
- (D) *The House of Delegates upon recommendation from the Council, may assess a nominal annual fee on Life and Emeritus members to cover administrative and overhead costs associated with providing Society publications and services.*

Section 4. Delinquency

Members are considered delinquent if their dues and assessments are not received by this Society by March 1, of each year, or by such other date as may be prescribed by the House of Delegates. Delinquent members shall not be entitled to any rights or benefits of this Society, nor shall they take part in any of its proceedings until such delinquency has been resolved.

Section 4. Suspension or Expulsion

Any person who is under sentence of suspension or expulsion from a component society or whose name has been dropped from its roll of members, shall not be entitled to any of the rights or benefits of this Society, nor shall he be permitted to take part in any of its proceedings until he has been relieved of such disability.

Section 5. Suspension or Termination of Membership

- A) Any member shall have their membership suspended or terminated for failure to pay their annual dues and assessments or upon official notification from a component society that a member is not in good standing, subject to the member's right of appeal as provided in Section 6 of this Chapter.
- (B) The Executive Committee, after due notice and hearing, may suspend or terminate a person's membership in the Arkansas Medical Society for an infraction of the Constitution or these Bylaws, for a violation of the Principles of Medical Ethics, or for unethical or illegal conduct, subject to the member's right of appeal as provided in Section 6 of this Chapter.
- (C) Membership in the Arkansas Medical Society shall automatically be terminated if a member ceases to meet the requirements for membership as specified in Section 1 of this Chapter. This provision shall not apply to Life or Emeritus members who have fully retired from the practice of medicine.

Section 5. Meeting Registration

Each member, each member chosen as a delegate, and each guest in attendance at an annual session of the Society shall register in such manner as may be provided by the Executive Vice President, giving his name, address, and the component society of which he is a member. When his right to membership has been verified by reference to the roster of his society, he shall receive a badge which shall be evidence of his right to all privileges of membership at that session. No member shall take part in any of the proceedings of an annual session until he has complied with the provisions of this section.

Section 6. Appeals

- (A) Any member who may feel aggrieved by the action of this Society or of the member's component society in denying membership, or in suspension or termination, shall have the right to appeal to the Council.

- (B) Notice of Appeal shall be filed with the Council within thirty (30) days of the date of the action on which the appeal is taken, and the appeal shall be perfected within ninety (90) days thereof. The decision of the Council shall be final.
- (C) The Council chairman shall have the power to appoint special committees from among the members of the Council to hear appeals; provided no member from the same councilor district as the appellant shall serve on said committee.
- (D) The Council shall establish rules and procedures to be followed in hearing appeals and shall furnish these to all parties involved in the appeal upon receipt of the Notice of Appeal.

Section 6. Continuing Medical Education

Continued membership in the Society is dependent upon compliance with continuing medical education requirements as specified below:

- (A) Classification of Members Affected
All members of the Society will comply with this charge, except those retired from practice, those still engaged in their formal medical or specialty education, non-resident members and those in full-time administrative positions. Those members unable to fulfill requirements because of impaired health or extenuating circumstances may be exempt on a temporary basis by the Committee on Continuing Medical Education.
- (B) Central Authority
The Committee on Continuing Medical Education will be charged with the determination of the requirements for maintaining membership in the Society. Their initial determination as well as any changes recommended must be submitted to the House of Delegates for approval. Alterations in the number of hours of continuing medical education required may be made at any regular meeting of the Society by the House of Delegates. The Council will serve as an arbitration committee if a decision of the Committee on Continuing Medical Education is questioned.
- (C) Acceptable Alternate Plans
Alternate plans of acceptable requirements which would be considered equal or exceeding the requirements established by the Committee on Continuing Medical Education and the House of Delegates would include:
 - (1) Compliance with the requirements for the Physician's Recognition Award of the American Medical Association;
 - (2) Compliance with the continuing education requirements of the American Academy of Family Physicians;
 - (3) Documentation of recertification by any specialty board provided the physician limits his practice to the definition of the specialty;

- (4) ~~The continuing medical education requirements of specialty societies other than the American Academy of Family Physicians should such become established. Such programs would be subject to review by the Committee on Continuing Medical Education prior to their acceptance.~~

(D) ~~Three-year Continuum~~

Each member subject to continuing medical education requirements shall have three years to complete the required hours. The three-year continuum begins January 1 of the initial year.

CHAPTER II. Annual and Special Sessions of the Society (Moved to Chapter III)

CHAPTER II. Component Societies (Formerly Chapter IX)

Section 1. Charters for Component Societies

- (A) All component societies now in affiliation with this Society or those which may hereafter be organized in this State, which have adopted principles of organization not in conflict with this Constitution and Bylaws, shall, on application and submission of their Constitution and Bylaws, receive a charter from and become a component part of this Society.
- (B) As rapidly as can be done after the adoption of this Constitution and Bylaws, a medical society shall be organized in every county in the State in which no component society exists, and charters shall be issued thereto.
- (C) Charters shall be issued only on approval of the Council, and shall be signed by the President and Secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Section 2. Component Organization

Only one component medical society shall be chartered in any county, except in the county where the University of Arkansas College of Medicine is located. In that county there may be, in addition to the regular county medical society, one component society for interns and residents and one component society for medical students. Where more than one component society exists in any other county, friendly overtures and concessions shall be made, with the aid of the councilor for the district if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Section 3. Membership Qualifications

Each component society shall be the judge of the qualifications of its own members, but as such societies are the only portals of this Society and to the American Medical Association, chartered components of the Arkansas Medical Society, every reputable person who

possesses the qualifications for membership required by Chapter I, Section 2 of these Bylaws, and who does not practice or claim to practice nor lend support to any exclusive system of medicine, shall be eligible for membership. No physician or surgeon who solicits patients or business for himself, or for an association or other organization of which he is a member, or by which he is employed, or in which he is interested, shall be eligible for membership in this Society, and no physician who works for, is employed by, or is interested in, any association or organization which solicits patients, members or physicians, shall be eligible for membership in this Society. Any member of the Society who shall hereafter violate any of the provisions hereof shall be expelled from the Society. Before a charter is issued to any county society, full and ample notice shall be given to every such physician in the county to become a member.

Section 4. Appeal to the Council

Any physician who may feel aggrieved by the any action of the Society of his county in refusing him membership or in censoring, suspending, or expelling him, shall have the right to appeal to the Council, and its decision shall be final except that a county component society shall at all times, be permitted to appeal or refer questions involving its membership to the House of Delegates of the Arkansas Medical Society for final determination. That the Council may be aided in rendering just decisions, it is necessary that the Bylaws of each component society provide in detail the procedure to be followed in preferring charges and trying any member accused of and tried for any kind of unprofessional conduct.

In hearing appeals the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts; but in case of every appeal, both as a Board and as individual councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Section 5. 4 Transfers

~~When a Members~~ in good standing in a component society who move to another county in this State he shall be given a written certificate of these facts by the secretary of his the component society, without cost, for transmission to the secretary of the society in the county to which he they move. Pending his their acceptance or rejection by the society in the county to which he they moves, such member shall be considered to be in good standing in the county society from which he was they were certified and in the state Arkansas Medical Society to the end of the period for which his their dues have been paid.

Section 6. 5 County Jurisdiction

A Physicians living near a county line may hold his their membership in that county society most convenient for him them to attend, on permission of the component society in whose jurisdiction he they reside.

Section 7. 6 Efforts to Increase Membership

Each component society shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Section 8. 7 Representation in the House of Delegates

- (A) ~~Each regular county medical society shall be entitled to one delegate to the House of Delegates of this Society for each twenty-five members or major fraction thereof, provided that the society has complied with other provisions of these Bylaws, and provided that each component society shall be entitled to one delegate.~~
- (B) ~~The component society of interns and residents shall be entitled to one delegate to the House of Delegates.~~
- (C) ~~The component society of medical students shall be entitled to one delegate to the House of Delegates.~~
- (D) At some meeting in advance of the Annual Session of this Society, each component society shall elect a delegate or delegates to represent it in the House of Delegates as provided in *Chapter IV, Section 7* of these Bylaws and the secretary of the component society shall send a list of such delegates to the Executive Vice President of this Society at least ten days before the Annual Session.

Section 9. 8 Responsibilities of secretary

The secretary of each component society shall endeavor to keep a roster of its members, and of the non-affiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state and such other information as may be deemed necessary. In keeping such roster, the secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his ~~the~~ annual report he shall endeavor to account for every physician who has lived in the county during the year.

Section 10. ~~Assessment~~

~~The Secretary of each component society shall forward its assessment, together with its roster of officers and members, list of delegates, and list of non-affiliated physicians of the county, to the Secretary of this Society on January 1st, and not later than March 1st of each year.~~

Section 9. Annual Report

The secretary of each component society shall forward its Annual Report to the offices of this Society no later than March 1 of each year. Such report shall include but not be limited to:

- A. *Names of officers and their terms*

- B. *Names of delegates*

- C. *Names of physicians who have been dropped from membership*

- D. *Names of deceased physicians*

- E. *Names of members requesting change in membership category*

- F. *Any dues and assessments collected by the component society in behalf of the Arkansas Medical Society and/or American Medical Association. Such monies shall be accompanied by a listing of the name, address, and amount remitted for each member.*

Section 11. Failure to Pay Assessment

Any county society which fails to pay its assessment, or make the report required, on or before March 1st, shall be held as suspended, and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

Section 10. Failure to Submit Annual Report

Any component society which fails to remit any dues and assessments collected in behalf of the Arkansas Medical Society and/or American Medical Association or who fails to submit the Annual Report, as defined in *Chapter II, Section 9*, on or before March 1 of each year, shall be held as suspended, and none of its members or delegates shall be permitted to participate in any of the business or proceedings of this Society or of the House of Delegates until such requirements have been met.

CHAPTER III. Annual And Special Sessions Of The Society

Section 1.

The Society shall hold an Annual Session of the House of Delegates at such place as has been fixed by the Council. ~~at the annual session two years in advance.~~

Section 2.

Special meetings of ~~either the Society or the~~ House of Delegates shall be called by the President on petition of the Council, twenty delegates, or fifty members.

CHAPTER III. General Meetings

Section 1.

~~All registered members may attend and participate in the proceedings and discussions of the general meetings and of the Section. The general meetings shall be presided over by the President or by one of the Vice Presidents, and before them shall be heard the address of the President and the orations, and such scientific papers and discussions as may be arranged for in the program.~~

Section 2.

~~The general meetings may recommend to the House of Delegates the appointments of committees or commissions for scientific investigations of special interest and importance to the profession and public.~~

CHAPTER IV. House Of Delegates

Section 1.

The House of Delegates shall meet on the first day of

the Annual Session. It may ~~adjourn~~ *recess* from time to time as may be necessary to complete its business; provided that its hours shall not conflict with the general meetings.

Section 2.

The order of business shall be arranged as a separate section of the Annual Session program.

Section 3.

The House of Delegates shall establish its own rules of procedure.

Section 4. Items of Business

- (A) All reports and resolutions received by the Executive Vice President sixty days prior to the annual meeting of the House of Delegates of this Society shall be printed in the Journal of the Arkansas Medical Society in the month preceding the meeting.
- (B) All reports, resolutions, and other items of business received by the Executive Vice President twenty days prior to a meeting of the House of Delegates shall be included in the meeting agenda.
- (C) Any item of business not submitted to the Executive Vice President twenty days prior to the meeting of the House of Delegates must have a two-thirds consent of attending delegates for introduction at such session.

Section 5. Reference Committees

- (A) The Speaker of the House of Delegates shall appoint an appropriate number of reference committees from the membership. ~~of the House of Delegates.~~ The Chairman shall be appointed by the Speaker. The reference committees shall serve only during the convention for which they are appointed.
- (B) All reports of committees, reports of officers, and resolutions submitted for consideration of the House of Delegates shall be referred to a reference committee, unless otherwise provided in these Bylaws, or unless otherwise ordered by a two-thirds vote of the House of Delegates.
- (C) The reference committee shall hold an open hearing at which any member of the Society may speak on proposals before the committee.
- (D) The reference committee shall recommend to the House of Delegates an appropriate course of action on each proposal referred to the committee.

Section 6. Composition

The House of Delegates shall consist of:

- (A) *Delegates elected by component societies in accordance with Section 7 of this chapter, or as provided in Section 10 of this chapter*
- (B) *The Councilors*
- (C) ~~Ex-officio, the~~ *The president, vice president, president-elect, speaker, vice speaker, secretary,*

treasurer, and past presidents of the Society; provided, however, that the ex-officio members shall have the power of voting on all subjects except the election of officers.

Section 6: 7 Representation of Component Societies

Representation for the House of Delegates shall be based upon the number of active, *active direct*, ~~members,~~ *life members,* ~~emeritus members,~~ and associate members as of December 31 of the year preceding the annual meeting. *Medical student and intern/resident members shall not be included in the enumeration of active and active direct members for purposes of representation.*

- (A) Each regular county society shall be entitled to send to the House of Delegates each year one delegate for every twenty-five Arkansas Medical Society members, as specified in ~~(A)(1)-this~~ *this* section, and one for each major fraction thereof, provided that its annual report and assessment are in the hands of the Executive Vice President by March 1st of each year. Each county society; ~~however, regardless of its number of members,~~ which has complied with this section, shall be entitled to *at least* one delegate.
- (B) The component society composed of ~~intern and~~ *intern/resident* members shall be entitled to one delegate to the House of Delegates.
- (C) The component society composed of *medical student* members shall be entitled to one delegate to the House of Delegates.

Section 7 8.

A majority of the delegates registered shall constitute a quorum.

Section 8:

~~The House of Delegates shall, through its officers, Council and otherwise, give diligent attention to and foster the scientific work and spirit of the Society and shall constantly study and strive to make each Annual Session a stepping stone to future ones of higher interest.~~

Section 9:

~~It shall consider and advise as to the material interest of the profession, and of the public in those important matters wherein it is dependent on the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse popular information in relation thereto.~~

Section 10:

~~It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse among physicians of the same locality, and shall continue these efforts until every physician in every county of the State who is reputable and eligible has been~~

brought under Medical Society influence.

Section 11.

It shall encourage postgraduate and research work, as well as home study, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

Section 12.

It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the constitution and bylaws of that body.

Section 13.

It shall divide the State into councilor districts, specifying what counties each district shall include and, when the best interest of the Society and profession will be promoted thereby, organize in each a district medical society, and all members of component societies the Arkansas Medical Society shall be members in such district society.

Section 14.

It shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

Section 15.

It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

Section 9. The House of Delegates shall:

- (A) elect representatives to the House of Delegates of the American Medical Association in accordance with the constitution and bylaws of that body,
- (B) divide the State into councilor districts, specifying what counties each district shall include and, when the best interest of the Society and profession will be promoted thereby, organize in each a district medical society, and all members of component societies the Arkansas Medical Society shall be members in such district society,
- (C) have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports,
- (D) approve all memorials and resolutions issued in the name of the Society before they shall become effective, and
- (E) it shall transact all business of this Society not otherwise provided for herein.

Section 16 10.

In case of vacancy in the office of delegate, the House of Delegates shall have the authority to seat any member of that county society in attendance at said meeting as delegate, with full right to perform all the duties of that office.

CHAPTER V. Election of Officers

Section 1. Nominating Committee

The Nominating Committee shall consist of ten members of the House of Delegates, one from each councilor district. Each member of the committee shall serve for a term of two years, the terms being staggered so that odd and even numbered councilor district representatives shall be replaced on alternate years. In the first year following adoption of this amendment, the odd numbered councilor district appointees shall serve for one year, the even numbered councilor district appointees shall serve for two years. The names of the delegates appointed to the nominating committee shall be submitted by the senior councilors in the districts to the Executive Vice President no later than thirty days prior to the annual meeting. Following the first meeting of the House of Delegates at the Annual Session, the Nominating Committee shall meet and organize by selecting a chairman and a secretary. It shall be the duty of this committee to consult with members of the Society and to hold one or more meetings at which time the best interest of the Society and of the profession of the State for the ensuing year shall be carefully considered. The committee shall report the result of its deliberations to the headquarters office no later than February 1 in the shape of a ticket containing the names of two or more members for the office of president-elect and names of one or more members for each of the other offices to be filled at the Annual Session. No two candidates for president-elect shall be named from the same county.

Section 2.

Nothing in this Chapter shall be construed to prevent additional nominations being made by members of the House of Delegates.

Section 3.

No member shall be eligible elected to any office of this Society who is not in attendance at the meeting at which the election is held. Exceptions may be made by the House of Delegates if the nominee is unable to be present because of circumstances beyond his control.

Section 4.

The election of officers shall be the first order of business of the House of Delegates on the last day of the Annual Session.

Section 5. Election by Ballot

All elections shall be by written ballot, except where there is only one candidate, when election may be made by acclamation, and a majority of the votes cast shall be necessary to elect.

Section 6. Terms of Office

~~Councilors shall be elected to serve a two-year term; all other terms of office are for one year. All officers shall serve until their successors are installed.~~

- (A) Councilors shall be elected to serve a two-year term; provided no councilor shall serve more than four consecutive terms.

- (B) *Delegates and Alternate Delegates to the American Medical Association shall be elected in accordance with the Bylaws of that organization.*
- (C) *All other terms of office shall be for one year; provided no member shall serve more than six consecutive years in the same office.*
- (D) *Members who have served in an office for the maximum number of years or terms are eligible for re-election to that same office after one year.*
- (E) *All officers shall serve until their successors are installed.*
- (F) *Provisions of this section shall supply to all current officers and fifty percent of their accumulated years in office shall count toward the specified limits.*
- (G) *Once provisions of this section have been implemented, paragraphs (F) and (G) shall be deleted from these bylaws.*

Section 7.

On the expiration of ~~his~~ *the* term as president-elect, that person shall automatically succeed to the presidency and shall serve as president for the ensuing year.

Section 8. Vacancy in Presidency

In the event of the death or removal of the President, the President-elect shall succeed to the presidency to serve the remainder of that year and the ensuing year.

Section 9. Vacancy in Office of President-elect

In the event of the death or removal of the President-elect or ~~his~~ *the* inability to serve, the ~~House of Delegates shall meet within thirty days in a special session or otherwise, called by the President, to nominate and elect a president-elect, provided that such death, removal or inability to serve shall occur not less than sixty days prior to the Annual Session, in which event the election shall be at the forthcoming Annual Session.~~ *Vice President shall succeed to the position until the next Annual Session at which time a special election for the office of President shall be held.*

Section 10. Councilor Vacancy

In the event of the death or resignation of a district councilor, the Council shall appoint a member of the district to fill the unexpired term. The remaining councilors for the district shall confer with members in the district and make nominations for the vacancy to the Council.

Section 11. Vacancy in Office of Secretary or Treasurer

In the event of a vacancy in the office of the Secretary or of the Treasurer, the Council shall fill the vacancy until the next annual election.

CHAPTER VI. Duties of Officers

Section 1. President

The President shall preside at all meetings of the Society and shall appoint all committees not otherwise provided for. ~~He~~ *The President* shall deliver an annual address at such time as may be arranged, and shall perform such duties as custom and parliamentary usage

may require. ~~He shall be the real head of the profession of the State during his term of office, and, as far as practicable, shall visit by appointment the various sections of the State and assist the councilors in building up the county societies, and in making their work more practical and useful.~~

Section 2. President-elect

The President-elect shall be a member of the Council and the House of Delegates. It shall be ~~his~~ *the President-elect's* duty to assist the President in visiting the component and district societies, and to ~~familiarize himself~~ *become familiar with*, and prepare ~~himself~~ *for*, the performance of ~~his~~ *the* duties ~~when he shall have succeeded to the presidency of the Society.~~ *of the office of President. In the event of the President's temporary inability to serve, the President-elect shall serve until such time as the President is able to return.*

Section 3. ~~Vice Presidents~~ Vice President

(A) ~~The First Vice President shall assist the President in the discharge of his the President's duties. In the event of the President's temporary inability to serve, the First Vice President shall serve in his stead.~~

(B) ~~The Vice Presidents may be assigned by the President of the Society as an ex-officio members of certain committees of the Society. The Vice President's responsibilities will be to stimulate, to guide, to maintain liaison, and to otherwise assist the assigned committees and their respective chairmen in the performance of their activities. In no instance will the Vice President usurp or supplant the committee chairman chairmen in his their responsibilities. The Vice President shall not have a vote in the affairs of the committees assigned to which he is assigned under provisions of this section.~~

Section 4. Treasurer

The Treasurer shall give bond in the sum as directed by the Council, ~~He~~ *and* shall demand and receive all funds due the Society, together with bequests and donations. ~~He~~ *The Treasurer* shall pay money out of the treasury only on a written order of the Executive Vice President; ~~he and~~ shall subject ~~his~~ *the Society's* accounts to such examinations as the House of Delegates may order. ~~and he~~ *The Treasurer* shall annually render an ~~account of his doings and of the state of the funds in his hands.~~ *accounting of the state of the Society's funds.*

Section 5. Secretary

The Secretary, in case of vacancy in the office of the executive vice president, shall assume the duties of that office pending the filling of the vacancy, and shall perform such other duties as are imposed by the Constitution and Bylaws. ~~He~~ *The Secretary* shall be the scientific and professional advisor of the Executive Vice President. ~~and shall assist the Executive Vice President concerning all matters without the jurisdiction of one not~~

~~holding the degree of Doctor of Medicine. The Secretary, as defined by the Constitution, shall be known as the Constitutional Secretary.~~

Section 6. The Speaker of the House

The Speaker of the House of Delegates shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

Section 7. The Vice Speaker

The Vice Speaker shall officiate for the Speaker in the latter's absence or ~~at his~~ by request. In case of death, resignation, or removal of the Speaker, the Vice Speaker shall officiate during the unexpired term.

Section 8. Councilors

~~Each~~ Every councilor shall be organizer, peace-maker, and censor for ~~his~~ their district. The one in each district with the longest tenure shall be considered the senior councilor. It is recommended that the councilors in each district call a meeting of the members in the district at least once each year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and for informing, improving, and increasing the knowledge and zeal of the component societies and their members.

~~The councilors shall jointly prepare and submit to the Council prior to the Annual Session a written report of their work and of the condition of the profession within their district.~~

~~The necessary traveling expenses incurred by each councilor in the line of the duties herein imposed may be allowed on submission of a properly itemized statement.~~

Section 9. Chairman of the Council

The Chairman of the Council shall (1) preside at all meetings of the Council, (2) serve as Chairman of the Executive Committee of the Council, and (3) appoint the Council committees.

CHAPTER VII. Council

Section 1. Power and Duties

- (A) The Council shall be the executive body of the House of Delegates and between Annual Sessions exercise the power conferred on the House of Delegates by the Constitution and Bylaws. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members ~~of component societies, on which an appeal is taken, from the decision of an individual councilor.~~ The Council shall elect a chairman following election of the Council members by the House of Delegates.

- (B) The Council shall be responsible for the conduct of all the business affairs of the Society. It shall employ a chief executive officer who shall be known as the Executive Vice President.

- (a) The Executive Vice President shall be responsible for implementation of policies of the Society and conducting affairs of the Society under the direction of the Council and its Executive Committee, the House of Delegates and the President. The Executive Vice President shall be the directing manager of the Society's headquarters office and the Journal office, and shall supervise the work of all salaried employees in the Society's offices. ~~He~~ The Executive Vice President shall discharge the administrative functions of the Society not within the duties of other officers or of committees to perform ~~He and~~ shall assist, at their request, all officers and committees. ~~and The Executive Vice President shall keep himself informed in regard to nonprofessional matters affecting the medical profession, for the purpose of keeping himself remaining~~ qualified to perform the services herein mentioned. The amount of his salary shall be fixed by the Council and ~~he the Executive Vice President~~ shall give bond as directed by the Council.

Section 2. Composition

The Council shall consist of the councilors, the president, vice president, president-elect, secretary, treasurer, immediate past president, and the Speaker of the House of Delegates. The Vice Speaker of the House of Delegates and the Delegates and Alternate Delegates to the American Medical Association shall be members ex-officio without vote.

There shall be two councilors from each district which has two hundred members or less. In districts where there are more than two hundred members, there shall be an additional councilor for each additional one hundred members. The councilors shall serve staggered terms of two years each. All councilors shall have equal voting privileges. A majority of the voting members shall constitute a quorum.

Section 3. Representation

Representation on the Council shall be based upon the enumeration of members in each councilor district in accordance with the provision for representation in the House of Delegates as defined in Chapter IV, Section 7 of these Bylaws.

Section 4. Organizing Component Societies

The Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided

for component societies until such counties shall be organized separately.

Section 3 5. Publications and Records

The Council shall provide for and superintend the publication and distribution of all proceedings, transactions and memories of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary. All money received by the Council and its agents, resulting from the discharge of the duties assigned to them, must be paid to the Treasurer of the Society. It shall annually audit the accounts of the Treasurer and Secretary and other agents of this Society and present a statement of the same in its annual report to the House of Delegates, which report shall also specify the character and cost of all the publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

Section 4 6. Meetings

The Council shall meet on the first day of the Annual Session and daily during the session and at such other times as necessary, subject to the call of the Chairman or on petition of three councilors. It shall meet on the last day of the Annual Session of the Society to organize and outline the work for the ensuing year. Between Annual Sessions, the Council shall be expected to meet at least bimonthly quarterly.

Section 5 7. Reporting

The Council shall, through its chairman, make an annual written report to the House of Delegates.

Section 6 8. Bonds

The Council shall have authority to accept or reject all bonds, commitments and contracts.

Section 7 9. Committees

(A) Executive Committee

The Chairman of the Council, the President, the President-elect, the Secretary, the Treasurer, and the Immediate Past President shall constitute the Executive Committee of the Council. The Chairman of the Council shall serve as Chairman of the Executive Committee. The Executive Committee shall have the power and authority to act for the Council between meetings of that body; all actions of the Executive Committee shall require approval or ratification of the Council. The Executive Committee shall consider matters referred to it by officers of the Society and shall report its findings or recommendations to the Council. *The Executive Committee shall have jurisdiction in all matters pertaining to (1) Active Direct membership and (2) discipline of members, subject to the member's right of appeal as provided in Chapter 1, Section 6 of these Bylaws.*

B) Budget Committee

The Budget Committee shall consist of (a) four

members appointed by the Chairman of the Council from among the councilors, and (b) the Arkansas Medical Society treasurer. The four council members shall be appointed to four-year terms, staggered so that one member is replaced each year. The terms shall begin on January 1 and end on December 31 of the appropriate years. The member with the most seniority shall serve as chairman. The Budget Committee shall present to the Council, before the first of each year, an annual budget consisting of anticipated revenue and expenses for the ensuing year as well as a report of the Society's committed and non-committed reserves. Any significant request for funds not included in the annual budget should be reviewed by the Budget Committee before they are committed. The Budget Committee shall provide for an annual independent financial audit and work to maintain the most prudent use of Society assets.

(B) (C) Council Committees

The Chairman shall, with concurrence of the Council, appoint such committees as are necessary to carry out the duties assigned to the Council by the Bylaws and House of Delegates. ~~At the discretion of the Council, the committees shall be of three types: (1) standing committees with unlimited membership tenure; (2) standing committees with staggered membership terms; and (3) ad hoc committees as may be warranted for specific purposes.~~

Section 8: 10. Appointments to Fill Vacancies

The Council shall, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates.

~~CHAPTER VIII. Committees~~

~~Section 1:~~

(A) ~~The standing committees of this Society shall be as follows:~~

1. Committee on Cancer Control
2. Committee of Medical Legislation/Subcommittee on National Legislation
3. Committee on Public Health/Subcommittees on Rural Health, Maternal and Child Welfare, Tuberculosis, Heart Association, Liaison with Nursing Profession, etc.
4. Committee on Continuing Medical Education
5. Committee on Hospitals/Hospital Liaison and Arkansas Hospital Association
6. Committee on Public Relations/Speakers' Bureau, Liaison with Auxiliary, Liaison with Medical Assistants, Civilian Defense, etc.
7. Committee on Annual Session
8. Committee on Insurance
9. Committee on Medicine and Religion

10. Committee on Aging

11. Committee on Mental Health

- (B) Additional committees shall be considered subcommittees of the appropriate standing committee and one member of the standing committee shall be a member of the subcommittee.
- (C) Unless otherwise provided, these committees shall be appointed by the President for three-year staggered terms. The committee shall consist of not less than six members each, with each president appointing two members for a three-year period. Any vacancies through death, removal or resignation may be filled by the President at the time the vacancy occurs and for the unexpired term of the vacancy. The President and the Secretary shall be ex-officio members of all committees.

Section 2. The Duties of the Committees shall be as follows:

Committee on Cancer Control. Shall represent the Society in all activities concerned with cancer in the State. Shall directly supervise the activities of the Cancer Control Committee of the Arkansas Medical Society Auxiliary. Shall cooperate with all agencies within the State of Arkansas dedicated to the problem of cancer.

Committee on Medical Legislation. Shall represent the Society in all legislative practice. It shall keep in touch with professional and public opinion and maintain active relations with the Department of Public Affairs of the American Medical Association. It shall, at all times, endeavor to shape and guide legislation with a view to securing the best results for the whole people. It shall strive to organize professional influence so as to promote the general good of the community in local, state, and national affairs and elections. During sessions of the General Assembly, it shall keep itself informed as to the bills that are introduced, and shall inform the members of the Society through its journal or special bulletins to the end that legislation inimical to the medical profession and the public shall be defeated, and legislation fostering the interest of the public health and medical practice shall be enacted into law.

Committee on Public Health. Shall represent the Society in those affairs having for their objective the improvement in public and personal health, the prevention of epidemics, and the instruction of the people. It shall maintain close relations with the Board of Health, the State Health Officer, and the various health officials, assisting in the adoption of public health programs, the enforcement of sanitary laws, and to exercise the leadership in the health problems of school children through a subcommittee on physical fitness and school health. As occasion demands, or when thought advisable, it shall supervise the preparation of articles of timely interest for publication in the newspapers or for broadcasting over the radio for the

instruction of the public.

The Committee on Continuing Medical Education shall be responsible for consideration of all questions pertaining to medical education. It shall maintain close relations with the officials and faculty of the University of Arkansas School of Medicine, and Arkansas Academy of Family Physicians, and other groups interested in maintaining and improving medical education in our State institutions. It shall foster continuous efforts to increase excellence in the system of post-graduate education to serve the cause of medicine and to assure the public of continuing improvement in the postgraduate training of physicians in practice.

The committee shall determine continuing medical education requirements for maintaining membership in the Society, as provided in these Bylaws, and shall establish methods of reporting in compliance with the continuing medical education requirements.

The Committee on Continuing Medical Education shall consist of seven members appointed by the President as follows: The dean or a representative of the University of Arkansas College of Medicine; one representative of the Arkansas Academy of Family Physicians from three nominees by that group; one family physician member of the Society selected by the President; one surgeon selected from three nominations from the Arkansas Chapter of the American College of Surgeons; one internist selected from three nominations from the Arkansas Chapter of the American College of Physicians and two other members of the Society, not in the specialty categories listed above, selected by the President. The committee chairman shall be named by the President.

Committee on Hospitals. The Committee on Hospitals shall have referred to it all questions pertaining to hospitals and their operations; hospitalization of patients and hospital-physician relationships.

Committee on Public Relations. The Committee shall have referred to it all questions wherein the medical profession as represented by the Society is called upon for advice, for participation in private or public affairs and projects not coming within the duties outlined for the other committees. It shall be the publicity committee of the Society and shall have charge of all publicity issued in the name of the Society. The subcommittee on professional relations shall function under this committee.

Committee on Annual Session. The committee shall determine the character and scope of the scientific program for each Annual Session. It shall prepare a scientific program for each Annual Session. It shall solicit and collect material from institutions and individual physicians of the State that is of scientific interest. This it shall arrange and exhibit at each Annual Session. It should particularly strive to obtain material that will more fully illustrate the papers presented in the general meeting of the Society.

The committee shall provide suitable accommoda-

tions for meetings of the Society and the House of Delegates, the scientific exhibits, the committees, and shall have general charge of all arrangements. Its chairman shall report an outline of the arrangements to the Executive Vice-President for publication in the program and shall make additional announcements during the session as occasion may require.

Committee on Insurance. The Committee on Insurance shall deal with all matters pertaining to insurance, including liaison with Blue Cross-Blue Shield.

The Committee on Medicine and Religion shall work to create and enhance communication between physician and clergyman which will lead to the most effective care and treatment of the patient in which both are interested. It shall study the areas in which there is or may be continuing correlation involving medicine and religion.

The Committee on Aging shall study the problems of the aged and the aging. It shall provide leadership and initiative in meeting the health and medical care requirements of older persons. It shall foster the development of effective methods of achieving the best possible social and spiritual atmosphere for the elderly.

The Committee on Mental Health shall study the problems of the mentally ill. It shall foster development of programs to improve the care and treatment of mental patients and mental retardates.

CHAPTER VIII. Committees

Section 1. Committees may be appointed by the president, chairman of the Council, or as may be so ordered by the House of Delegates to carry out the goals and responsibilities of this Society.

Section 2. Unless otherwise provided, all committees will be of two types: (1) Standing committees with staggered membership terms; and (2) Ad Hoc committees and Task Forces for specific purposes with limited duration.

Section 3. All committees shall have a written mission-statement that includes to whom the committee reports, the goal or purpose of the committee, and when applicable, the perceived or required time-frame for completion of the committee's work.

Section 4. All committees except those required by the Constitution and Bylaws shall be evaluated periodically, but not less than once every three years, to identify and abolish or restructure committees that are non-functional or whose purpose or mission has significantly changed or ended. It shall be the responsibility of the Executive Committee to conduct such evaluation and make recommendations to the appropriate body.

Section 5. Unless otherwise provided, standing committees shall consist of at least six members with each member appointed to a three-year term; provided no member shall serve more than two consecutive terms.

CHAPTER IX. Component Societies (Changed to Chapter II)

CHAPTER IX. Required Attendance By Elected And Appointed Members

Any member, appointed or elected, to any position within this Society who is absent from three consecutive meetings, or who annually misses fifty percent of the meetings of the body to which they serve, shall be presumed to have resigned that position, provided, written notification has been given prior to a person missing the critical number of absences.

CHAPTER X. Miscellaneous

Section 1:

No address or paper before this Society, except those of the President and orators, shall occupy more than thirty minutes in its delivery and no member shall speak longer than five minutes nor more than once on any subject, except by unanimous consent.

Section 2:

All papers read before the Society or any of the sections shall become its property. Each paper shall be deposited with the Secretary when read.

CHAPTER XI. Parliamentary Procedures

The deliberations of this Society shall be governed by parliamentary usage as contained in Sturgis Rules of Parliamentary Procedure, when not in conflict with this Constitution and Bylaws.

CHAPTER XII. Medical Ethics

The Principles of Medical Ethics promulgated by the American Medical Association shall govern the conduct of members in their relation to each other and to the public.

CHAPTER XIII. Amendments

The House of Delegates may amend any chapter of these Bylaws by a two-thirds vote of the delegates present at any Annual Session, provided that each amendment shall have been presented in open meeting at the previous Annual Session, and that it shall have been published twice during the year in a bulletin or journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken. meeting of the House of Delegates, provided that the amendment shall have been mailed to all members at least 90 days prior to the meeting.



AMS Newsmakers

The Arkansas Medical Society recently announced the new Student Officers for 1991. They are: **John Gaston**, president-sophomore; **Juan Hughes**, vice president-sophomore; **Kim Garner**, secretary/treasurer-freshman; **Katherine Henry**, AMS delegate-freshman; and, **Elise Fortin**, AMS alternate delegate-freshman.

Baptist Medical Center in Little Rock and Baptist Memorial Medical Center in North Little Rock have elected their new chiefs for their medical sections and new chief of staffs.

At Baptist Medical Center, they are **Dr. David A. Smith**, chief of cardiology; **Dr. Bill Ball**, chief of family practice section; **Dr. Max Baldwin**, chief of OB/GYN; and, **Dr. Van Stone**, chief of pediatrics section.

At Baptist Memorial Medical Center, they are **Dr. Ernest Harper**, chief of medicine section; **Dr. Marion Church**, chief of OB/GYN section; **Dr. Jan Scruggs**, surgery section chief; and, **Dr. Eric Fraser**, chief of pediatrics.

The employees of Crestview Family Practice Clinic recently honored **George McCrary, M.D.** for 20 years of service to the citizens of Jacksonville and the medical clinic that he founded with the late James Durham, M.D.

Jim McCoy, M.D., an orthopedic surgeon in Searcy, was recently elected to the board of trustees of the Baptist Medical Systems Corporation.

Robert Searcy, M.D., of Little Rock, was recently honored at a reception and presented a certificate of appreciation for his generous contribution to the Lonoke County Open Arms Shelter. Dr. Searcy is associated with the Little Rock Diagnostic Clinic.

Sparks Regional Medical Center and St. Edward Mercy Medical Center have named their chiefs of staff for 1991.

At Sparks Regional Medical Center, they are: **Dr. Bruce Glover**, chief of medical staff; **Dr. John Wikman**, secretary; **Dr. Robert Fiser**, anesthesia; **Dr. Robert Hughes**, eye, ear, nose, and throat; **Dr. Eldon Pence**, medicine; **Dr. James Barry**, neurology; **Dr. Jimmie Atkins**, OB/GYN; **Dr. A.B. Hathcock**, orthopaedics; **Dr. Annette Landrum**, pathology; **Dr. Joe Dorzab**, psychiatry; **Dr. James Gill**, radiology; **Dr. Sam Landrum**, surgery; and, **Dr. John Lange**, urology.

At St. Edward Mercy Medical Center, they are: **Dr. Gene Still II**, chief of staff; **Dr. Ron Robinson**, chief of

staff-elect; **Dr. Terry Hunton**, anesthesia; **Dr. William Holman**, cardiology; **Dr. Robert Hughes**, eye, ear, nose, and throat; **Dr. Allen Beachy**, family practice; **Dr. Christina Jefferson**, internal medicine; **Dr. William Knubley**, neurology; **Dr. John Hoffman**, OB/GYN; **Dr. John Wells**, oncology; **Dr. Claude Martimbeau**, orthopedics; **Dr. Leo Davenport**, pathology; **Dr. James Cheshier**, pediatrics; **Dr. Leo Drolshagen**, radiology; and, **Dr. W.C. Holmes**, surgery.

Robert White, M.D., of Paragould, has been elected chief of staff at Arkansas Methodist Hospital in Paragould.

Physician's Recognition Award

The Physician's Recognition Award is awarded each month to physicians who have completed acceptable programs of continuing education. The recipients for the months of November, December, and January are:

John E. Alexander	Magnolia
Leslie F. Anderson	Lonoke
Zvi Aviner	Blythville
James D. Billie	Little Rock
William B. Bishop	Little Rock
Jerry C. Chapman	Cabot
William E. Finfrock	Eureka Springs
Adrian L. Herren	Fort Smith
Gregory McNamara	Little Rock
Edwin F. Price	Jonesboro
Wilson F. Rigler	Mountain Home
Ben N. Saltzman	Little Rock
Thomas J. Smith	Little Rock
Alan R. Storeygard	Jacksonville

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John E. Green, Jr.

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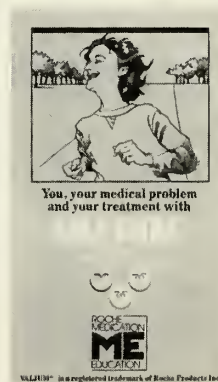
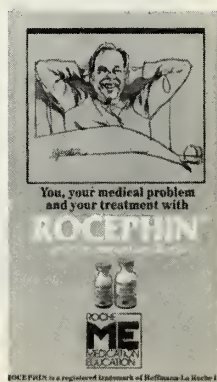
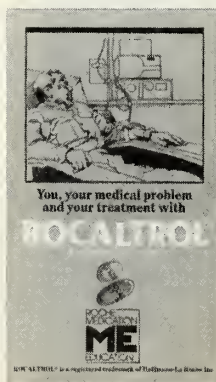
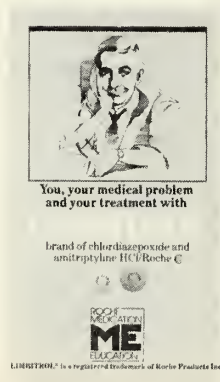
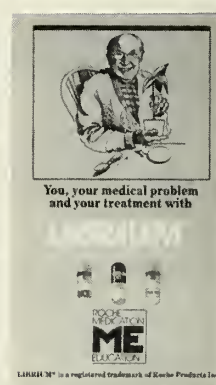
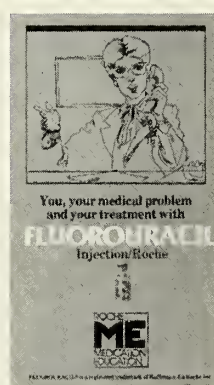
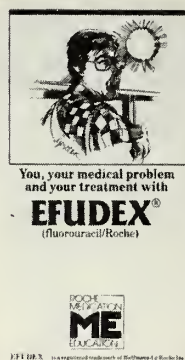
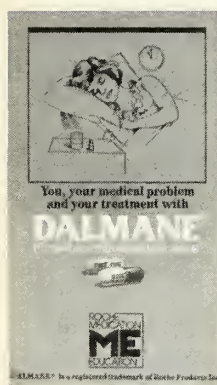
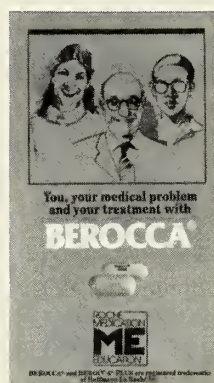
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New Members

BENTON COUNTY

Benson, Stuart J., Internal Medicine, Bella Vista. Born September 13, 1957, Williamsburg, VA. Medical education, University of Osteopathic Medicine and Health Sciences, Des Moines, Iowa, 1986. Internship/residency, Tulsa Regional Medical Center, OK, 1990. Board eligible.

Keane, Patrick K., General Surgery, Bentonville. Born July 19, 1944, Denver, CO. Medical education, University of Wisconsin Medical School, 1969. Internship, San Joaquin County Hospital, Stockton, CA, 1970. Residency, University Hospitals, Madison, WI, 1976. Board certified. Practice experience, 14 years.

BOONE COUNTY

Langston, Thomas A., Family Practice, Harrison. Born February 16, 1962, Harrison. Medical education, UAMS, Little Rock, 1987. Internship/residency, AHEC-Northwest, Fayetteville, 1990. Board certified.

CRAIGHEAD COUNTY

Ragland, Darrell G., Family Practice, Jonesboro. Born June 26, 1959, Fayetteville. Medical education, UAMS, Little Rock, 1987. Internship/residency, AHEC-Northeast, 1988. Board certified. Practice experience, 2 years.

GARLAND COUNTY

Martin, Jana M., Pediatrics, Hot Springs. Born January 7, 1959, San Diego, CA. Medical education, University of Texas Medical School, San Antonio, 1986. Internship/residency, University of Texas Medical School, Houston, 1989. Board certified.

GREENE-CLAY COUNTY

Rollins, William H., Urology, Paragould. Born August 15, 1937, Seattle, WA. Medical education, University of Washington, Seattle, 1963. Internship, Hennepin County, Minneapolis, MN, 1964; Swedish Hospital, Seattle, WA, 1965. Residency, University of Washington, 1971. Board certified. Practice experience, 19 years.

Smith, Norman E., OB/GYN, Brentwood, MO. Born August 5, 1954, St. Louis, MO. Medical education, St. Louis University, MO, 1978. Internship/residency, St. Louis University Hospitals, 1986. Board certified. Practice experience, 4 years.

Anders, Ernest R., General Practice, Paragould. Born June 29, 1936, Galveston, TX. Medical education, University of Texas Medical School, Galveston, 1963. Internship, Good Samaritan, Dayton, OH, 1964. Practice experience, 24 years.

SEVIER COUNTY

Mielnick, Alina, Urology, De Queen. Born May 25, 1949, Poland. Medical education, Warsaw Medical School, Poland, 1979. Internship, Stony Brook University Hospital, 1981. Residency, Downstate Medical Center, Brooklyn, NY, 1985. Practice experience, 4 years. Board eligible.

ST. FRANCIS COUNTY

Burnette Sr., David B., Family/General Practice, Forrest City. Born December 16, 1954, Norton, VA. Medical education, West Virginia School of Osteopathic Medicine, Lewisburg, VA, 1985. Internship, C.E. Still Hospital/University of Missouri, Jefferson City, 1986. Practice experience, 4 years.

TRI-COUNTY COUNTY

Hiese, Lawrence F., Family/General Practice, Horse Shoe Bend. Born April 7, 1923, Milwaukee County, WI. Medical education, Marquette University, 1947. Internship, Mercy Hospital, Oshkosh, WI. Practice experience, 42 years.

WHITE COUNTY

Taylor, David H., Internal Medicine, Searcy. Born August 31, 1953, Wynne. Medical education, UAMS, Little Rock, 1981. Internship/residency, Robert Packer Hospital, Sayre, PA, 1984. Practice experience, 6 years. Board certified.

RESIDENT

Collins, Harold B., OB/GYN. Born November 23, 1962, Memphis, TN. Medical education, University of Tennessee, Memphis, 1989. Internship/residency, UAMS.

Connelly, Steven N., Emergency Medicine. Born October 29, 1959, Shreveport, LA. Medical education, UAMS, 1986. Internship, Oakland Naval Hospital, CA. Residency, UAMS.

Montgomery, Lori E., Pediatrics. Born October 27, 1961, Dallas, TX. Medical education, UAMS, 1989. Internship, UAMS.

Nunnally, Frederick K., Otolaryngology. Born December 29, 1960, Fayetteville. Medical education, UAMS, 1987. Internship, University of Florida, 1988. Residency, University of Tennessee.

Smith, Amy S., Psychiatry. Born May 13, 1964, Topeka, KS. Medical education, University of Kansas Medical Center, Kansas City, 1990. Residency, UAMS.

Medicine in the News

Health Care Access Foundation Update

As of January 1991, the Arkansas Health Care Access Foundation has provided free medical services to 2,416 medically indigent persons.

The program has 1,439 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.

Fellowship in Occupational Medicine

The Department of Family and Community Medicine and the Department of Pharmacology and Toxicology at the University of Arkansas for Medical Sciences are jointly sponsoring a Fellowship in Occupational Medicine slated to begin in July 1991. The Fellowship is highly flexible and may be structured to meet the educational needs of the trainee. A full-time, one year program or a self-paced, part-time program may be developed for the trainee. Primary care or emergency medicine physicians will be offered didactic training in neurology, orthopedics, dermatology, and emergency medicine as well as on-site clinical experience. Coursework in epidemiology, biostatistics and other pertinent areas is also available. More information about the program is available from the Department of Family and Community Medicine, UAMS, 4301 W. Markham, Slot 530, Little Rock, AR 72205.

New Medicare Rule on Mammography Screening

Mammography screening for breast cancer will be covered by Medicare under a federal rule published in January 1991. Women included are those over 65 and those younger women qualifying for Medicare benefits due to handicaps.

The interim final rule, issued by the Health Care Financing Administration (HCFA) on January 1, includes quality control and quality assurance measures. Besides listing physician requirements, HCFA also spelled out standards for mammographic equipment.

Under the rule, the reimbursement limit for mammography services performed this year is \$55.00. In the future, the amount will rise to coincide with the percentage increase in the Medicare Economic Index, according to HCFA.

Comments on the rule, which implements a section of the Budget Reconciliation Act of 1990, will be accepted

by HCFA until March 1. The comments will be considered before final regulations are published.

In its publication, HCFA acknowledges that rule reflects safety, educational, and technical requirements previously developed by the American College of Radiology (ACR). The requirements have been part of the ACR's mammography accreditation program since 1987.

Specifically, HCFA will cover asymptomatic women 65 and over a screening mammogram every two years. Women with symptoms would need a diagnostic, or more detailed mammographic examination and this procedure already is covered by HCFA under earlier regulations.

While the majority of women covered by Medicare are over 65, thousands of younger women with disabilities are covered by the program. The rule does allow for reimbursement for women in the 34 to 65 year old group, with certain restrictions.

More frequent screening is covered for women considered in "high risk" categories. These include women with a personal or family history of breast cancer and women who have not given birth by age 30.

The rule also requires that interpretation by a "qualified physician" be part of each covered mammographic screening examination. In addition, the rule requires that this physician be certified by the American Board of Radiology or by the American Osteopathic Board of Radiology or is certified by "an appropriate program as determined by the secretary of the Department of Health and Human Services.

Ophthalmologists Offer Help During "Operation Desert Storm"

The president of the American Academy of Ophthalmology has offered the assistance of volunteer ophthalmologists to the Department of Defense and Veterans Administration hospitals during Operation Desert Storm.

"The American Academy of Ophthalmology, recognizing the potential shortage of ophthalmologists at some military hospitals in the U.S. due to the deployment of many physicians in Operation Desert Storm, offers any assistance that may be needed," said George W. Weinstein, M.D., president of the Academy.

"Similarly, if during this action, the need for professional manpower should exist at any VA Hospital or Department of Defense facility, the American Academy of Ophthalmology will support a call for volunteer ophthalmologists to work with state ophthalmological societies to provide support to this effort."

API Helps Its "Desert Storm" Doctors

American Physicians Insurance Exchange (API) is making an exception for any doctor whose status has changed from reserve to active duty because of the Middle East Crisis. Premium payments will be suspended while they are on active duty status.

Although this will eliminate the normal charges for unknown and unreported claims that are inherent when medical malpractice coverage ceases, it will preserve protection for doctors for the period of time that their policies were in force.

"This action will relieve the anxiety and worry experienced by doctors over claims that may arise while they are away. We are here to serve the unique needs of our members who are called to active duty and welcome the opportunity to respond to these circumstances over which they have no control," says Frank S. Martin, M.D., chairman of API.

Doctors should contact API for further details about the action they need to take in order to obtain the benefit of this decision. If notification to report to active duty has already been received, the company should be notified immediately to assure that the necessary steps to qualify are taken.

Nasal Surgery: Most Common Facial Plastic Surgery Procedure

More and more people who are dissatisfied with their noses are having them changed. Nasal surgery, or rhinoplasty, is the most common facial plastic surgery procedure performed today. In fact, more than 150,000 surgeries are done every year, according to the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS).

Ethics of HIV Positive Physicians

In response to the CDC report on three dental patients who apparently contracted HIV from their dentist, the AMA recently issued a statement about the ethics of HIV positive physicians and their contacts with patients.

"Physicians who are HIV positive have an ethical obligation not to engage in any professional activity which has an identifiable risk of transmission of the infection to the patient" (See *Report AMA Council on Ethical and Judicial Affairs, Ethical Issues Involved in the Growing AIDS Crisis*, Dec. 1987; reprinted JAMA, 1988; 259:1360-61). Many patients have been treated by HIV infected physicians and there have been no documented cases of transmission from physician to patient.

However, the recent cases of possible dentist to patient transmission have caused some uncertainty about the risk of transmission from physicians to patients under certain circumstances. In cases of uncertainty about risks to patient health, the medical profession, as a matter of medical ethics, should err on the side of protecting

patients. The health of patients must always be the paramount concern of physicians. Consequently, until the uncertainty about transmission is resolved, the AMA believes that HIV infected physicians should not perform invasive procedures which pose an identifiable risk of transmission or should disclose their sero-positive status prior to performing the procedure and proceed only if there is informed consent. As a corollary, physicians who are at risk of acquiring HIV infection, and who perform such invasive procedures, should periodically determine their HIV status.

Some invasive procedures pose no identifiable risk of transmission, e.g., a bronchoscopy. Others, such as surgical procedures, cannot, with the same conclusiveness, be said at this time to pose no identifiable risk of transmission given the current analysis of the CDC regarding three patients of a Florida dentist.

The AMA further believes that physicians who are HIV positive and who must restrict their normal professional activities have a right to continue their career in medicine in a capacity that poses no identifiable risk to their patients. The AMA pledges its support and protection of these physicians and believes the profession and the public have an obligation to ensure that they continue to be productive as long as they practice medicine safely and responsibly.

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In Memoriam

Lucas M. Byrd, M.D.

Lucas M. Byrd, M.D., of Little Rock, died Tuesday, January 15, 1991. He was 76.

Dr. Byrd was a retired anesthesiologist for Baptist Medical Center and a Air Force veteran of World War II. He was a member of the Arkansas Medical Society, the American Medical Association, Pulaski County Medical Society, and the American Society of Anesthesiologists.

Dr. Byrd is survived by two daughters, Linda Smith of Little Rock and Carol Burt of Mena; two sisters, Maxie Grainger and Florence Sparks, both of Little Rock; and five grandchildren.

Onyx Pickney Garner, M.D.

Onyx Pickney Garner, M.D., of New Orleans, LA, formerly of Hot Springs, died Tuesday, February 5, 1991. He was 85.

Dr. Garner was a Fellow of the American College of Surgeons and a member of the American Medical Association and Arkansas and Garland County Medical Societies.

Dr. Garner is survived by two sons, Dr. Onyx P. Garner Jr. of New Orleans and Dr. John W. Garner of Pensacola, FL; a daughter, Elizabeth Joann Brown of Wynne; a brother, Dr. Byron O. Garner of Los Cruces, NM; and six grandchildren.

Custom Furniture for Homes



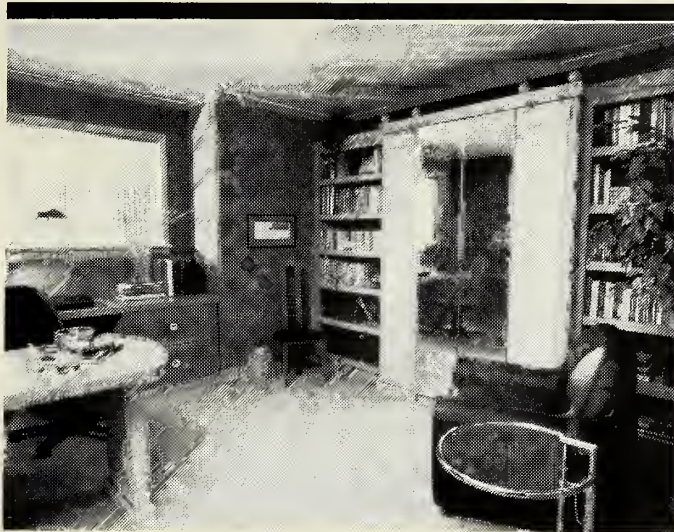
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Resolution

Lucas M. Byrd, M.D.

Whereas, the members of the Pulaski County Medical Society note with sincere sorrow the recent death of their dear colleague, Lucas M. Byrd, M.D.; and

Whereas, he had been a loyal member of this Society for thirty-four years and was held in the highest esteem for his devotion to his speciality of anesthesiology; and

Whereas, his service in the Air Force during World War II gave evidence of his devotion to his country, and his empathy and concern for his patients gave evidence of his devotion to his fellow man; be it therefore

RESOLVED, that this resolution be adopted and made a part of the permanent archives of this Society; and

RESOLVED, that a copy of this resolution be sent to Dr. Byrd's family as a token of our sincere sympathy; and

RESOLVED, that a copy be sent to *The Journal of the Arkansas Medical Society* for publication.

Adopted
Executive Committee
January 16, 1991

By Order of the Memorials Committee
Marlon J. Doucet, M.D., Chairman
Henry Hollenberg, M.D.
Robert Watson, M.D.

AIDS IN ARKANSAS 1991

January 1 - December 31, 1991

Total number of cases

reported 14

Number of deaths 7

CASES BY SEX

Male 12

Female 2

CASES BY RACE

White 10

Black 4

Other 0

CASES BY RISK GROUP

Homosexual/Bisexual 8

Homosexual & IV Drug User 3

IV Drug User 1

Hemophiliac 0

Transfusion 0

Heterosexual (Contacts) 1

NIR# 1

No identified risk group (NIR)

CASES BY AGE GROUP

Less than 20 1

20 - 29 3

30 - 39 4

40 - 49 5

50 or more 1

OPPORTUNISTIC DISEASE

Pneumocystic Carinii 7

Cryptococcosis 0

Kaposi's Sarcoma 1

Candida 1

HIV Wasting Syndrome 0

Toxoplasmosis 0

HIV Encephalopathy 1

Histoplasmosis 2

Other Diseases 2

AIDS IN ARKANSAS

1985 - 1991

Total number of cases

reported 457

Number of deaths 275

CASES BY SEX

Male 414

Female 43

CASES BY RACE

White 344

Black 108

Other 5

CASES BY RISK GROUP

Homosexual/Bisexual 290

Homosexual & IV Drug User 48

IV Drug User 45

Hemophiliac 7

Transfusion 19

Heterosexual (Contacts) 24

NIR# 24

No identified risk group (NIR)

CASES BY AGE GROUP

Less than 20 15

20 - 29 140

30 - 39 198

40 - 49 72

50 or more 32

OPPORTUNISTIC DISEASE

Pneumocystic Carinii 209

Cryptococcosis 22

Kaposi's Sarcoma 13

Candida 57

HIV Wasting Syndrome 50

Toxoplasmosis 8

HIV Encephalopathy 25

Histoplasmosis 31

Other Diseases 40

Source: Arkansas Department of Health.

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Things To Come

April 10-13

Treatment of Surgical Spine Disease, The Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Washington University School of Medicine. For more information, call Cathy Caruso at 1-800-325-9862.

April 17-21

5th Annual Critical Care Update, The Crowne Plaza Hotel, Rockville, MD. Sponsored by the Society of Critical Care Medicine and Rush-Presbyterian-St. Luke's Medical Center. Fees: \$695.00, physicians; \$525, physicians in training and allied health professionals. Category I credits available. For more information, call (201) 385-8080.

April 19-21

Focus on the Athletic Patient. The Cottages, Hilton Head, SC. Sponsored by the Southern Medical Association. CME Category I credits available. For more information, call LaDonna Nail at 1-800-423-4992.

April 19-21

Advances in Surgical Techniques and Technologies. The Homestead, Hot Springs, VA. Sponsored by the Southern Medical Association. CME Category I credits available. For more information, call LaDonna Nail at 1-800-423-4992.

April 21-23

8th National Conference on Prescription Medicine Information and Education. Omni Shoreham Hotel, Washington DC. Sponsored by the National Council on Patient Information and Education. For more information, call (202) 347-6711.

April 25-26

8th Annual Symposium on Obstetrics & Gynecology. Wohl Auditorium, Washington University Medical Center, St. Louis, MO. Sponsored by the Washington University School of Medicine and presented by the Department of OB/GYN and the Office of CME. CME Category I credits available. Fees: \$250, physicians; \$125, physician in training and allied health professionals. For more information, call Cathy Caruso at 1-800-325-9862.

April 26-28

Diagnostic Dilemmas in Cardiology. Kingston Plantation, Myrtle Beach, SC. Sponsored by the Southern Medical Association. CME Category I credits available. For more information, call LaDonna Nail at 1-800-423-4992.

April 30-May 2

Molecular Basis of Bone Cell Physiology: Transcellular Signaling, The Sheraton West Port Inn, St. Louis, MO. Sponsored by the Washington University School of Medicine. For more information, call Cathy Caruso at 1-800-325-9862.

May 1-3

Protection for Research Risk, The Hyatt Regency, Union Station, St. Louis, MO. Sponsored by the Washington University School of Medicine. For more information, call Cathy Caruso at 1-800-325-9862.

May 3-5

Diagnostic Dilemmas in Neurology and Psychiatry. The Grand Hotel, Point Clear, AL. Sponsored by the Southern Medical Association. CME Category I credits available. For more information, call LaDonna Nail at 1-800-423-4992.

May 17-18

Low Back & Sciatic Pain: Evaluation and Treatment. Washington University Medical Center, St. Louis, MO. Sponsored by Washington University Medical Center. For more information, call Cathy Caruso at 1-800-325-9862.

June 17-19

Breast Cancer Diagnosis: Interventional Procedures. The Westin Resort, Hilton Head, SC. Sponsored by Siemens Medical Systems, Inc. For more information, call Ted Pensiero (908) 906-3807 or Jenny Adamiec (908) 906-3800.

August 1-3

Financial Management Conference. Mariner's Inn, Hilton Head Island, SC. Sponsored by the Medical College of Georgia. For more information, call Donald Murphy or John Norcross at 1-800-221-6437.

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Am Fam Phys 1987;36:133-140

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Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β -hemolytic streptococci).

Contraindication: Known allergy to cephalosporins.
Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of non-susceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, serum-sickness-like reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
- Stevens-Johnson syndrome, toxic epidermal necrolysis,

and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.

- Gastrointestinal (mostly diarrhea); 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

Abnormalities in laboratory results of uncertain etiology.

- Slight elevations in hepatic enzymes.
- Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
- Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Ceclor and Coumadin concomitantly.
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest[®] tablets but not with Tes-Tape[®] (glucose enzymatic test strip, Lilly).

PA 8791 AMP [021490 LRI]
Additional information available to the profession
on request from Eli Lilly and Company, Indianapolis,
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Keeping Up

Febrile Infant Evaluation

March 12, 12:00 noon. Sponsored by AHEC Fort Smith and presented by Richard Jacobs, M.D. Doctors' Conference Room, basement, Sparks Regional Medical Center.

Outpatient Management of Diabetes

March 14, 12:00 noon. Sponsored by AHEC Fort Smith and presented by Don Miller, M.D. 7th Floor Dining Room, Sparks Regional Medical Center.

Anti-microbial Therapy in Pulmonary Infections

March 19, 12:00 noon. Sponsored by AHEC Fort Smith and presented by Richard Quintiliani, M.D. 7th Floor Dining Room, Sparks Regional Medical Center.

Patient Selection & Technique in Thrombolytic Therapy

March 19, 7:00 p.m. Sponsored by Baxter County Regional Hospital and presented by Timothy McCowan, M.D. and John Eidt, M.D. Education Bldg., Baxter County Regional Hospital, Mountain Home. Category I credit offered.

Surgery for Epilepsy

March 20, 12:00 noon. Sponsored by AHEC Fort Smith and presented by Rick Boop, M.D. 7th Floor Dining Room, Sparks Regional Medical Center.

PET Scanning

March 23, time to be announced. Sponsored by UAMS College of Medicine and presented by E.J. Towbin, M.D. UAMS Education II Bldg.

Symposium on Critical Care and Emergency Medicine

April 4-6, time to be announced. Sponsored by UAMS College of Medicine and presented by Terry Yamauchi, M.D. and Milton D. Deneke, M.D. Arlington Hotel, Hot Springs. Fee: \$195.00. Category I credit offered.

University Based Perinatal Seminar

April 5, time to be announced. Sponsored by UAMS College of Medicine and presented by J. Gerald Quirk, M.D. Arkansas Children's Hospital Sturgis Auditorium. Fees: \$10.00 and \$20.00. Category I credit offered.

Allergic Rhinitis

April 9, 12:00 noon. Sponsored by AHEC Fort Smith and presented by Edwin Whiteside, M.D. 7th Floor Dining Room, Sparks Regional Medical Center.

Lung Cancer - Methods of Treatment

April 16, 7:00 p.m. Sponsored by Baxter County Regional Hospital and presented by Clifton F. Mountain, M.D. Education Bldg., Baxter County Regional Hospital, Mountain Home. Category I credit offered.

Cholesterol and Coronary Disease

April 17, 12:00 noon. Sponsored by AHEC Fort Smith and presented by Joseph Carver, M.D. 7th Floor Dining Room, Sparks Regional Medical Center.

GRECC Annual Spring Meeting

April 17, time to be announced. Sponsored by UAMS College of Medicine and presented by David A. Lipschitz, M.D. and Ronni Chernoff, Ph.D. Excelsior Hotel, Little Rock. Fees: to be announced.

Anti-convulsants in Pregnancy

April 30, 12:00 noon. Sponsored by AHEC Fort Smith and presented by Greg Sharp, M.D. 7th Floor Dining Room, Sparks Regional Medical Center.

8th Annual W.W. Stead Arkansas Chest Symposium

May 4-5, times to be announced. Sponsored by UAMS College of Medicine and presented by F. Charles Hiller, M.D. University Conference Center Statehouse Plaza, Little Rock. Fee and credit to be announced.

13th Annual Family Practice Intensive Review

June 7-9, times to be announced. Sponsored by UAMS College of Medicine and presented by Ben Saltzman, M.D. UAMS Education II Bldg. Fee: \$200.00. Credits to be announced.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

CME Luncheon, second & fourth Friday, 12:30 p.m. AMI Ozark-Quapaw Room. One Category I credit per meeting.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), third Wednesday, 12:30 p.m., conference room, Bldg. 1, VAMC

Medical Grand Rounds, Fridays, 12:00 noon, VAMC

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Faculty Resident Seminar, third Thursday, 12:00 noon, Sturgis Auditorium

Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457

Infectious Disease Conference, second Wednesday, 12:00 noon, 2nd Floor Classroom

Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium

Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., 2nd Floor Classroom

Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, 2nd Classroom

Pediatric Research Conference, first Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

Sleep Disorders Case Conference, first & third Thursday, video production conference room. Lunch provided

Interdisciplinary AIDS Conference, second Friday, 12:00 noon. LaHarpe Room. Sandwich buffet is served

Cancer Conference, third Thursday, 12:00 noon, Laboratory conference room. Lunch is provided

Hematology-Oncology Conference, second Thursday, 12:00 noon. Lunch is provided

Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments are provided

Pulmonary Conference, second & fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet is served

Journal Club, every Tuesday, 12:00 noon, Lunch is provided

GYN Surgery Cancer Conference, second Monday, 12:00 noon. Lunch is provided

Joint Tumor Conference, first Wednesday, 12:00 noon. CARTI Auditorium. Lunch is provided

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., conference room 1

GI Conference, fourth Friday, 12:00 noon. Lunch is provided

Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lectures & case presentations. A light lunch is provided

Pathology Conference, first Tuesday, 3:00 p.m., Pathology Library

Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor/BMC. Lunch is provided

Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch is provided

Sleep Case Conference, Fridays, 12:00 noon. Lunch is provided

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC Oncology Forum, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits

Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B

Anesthesia Morbidity & Mortality Conference, Tuesdays, 6:45 a.m.; second & fourth Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B

Arkansas Blood & Cancer Society Conference, sixth Thursday, 7:30 p.m. Terrace Restaurant, Little Rock

CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy

Cardiothoracic Surgery Conference, date, time, & location varies

Cardiothoracic Surgery Monthly Journals Club, fourth Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D

Cardiothoracic Surgery Morbidity & Mortality Conference, second Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D

Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B

Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B

Emergency Medicine Grand Rounds 1, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B

Emergency Medicine Grand Rounds 2, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B

Gastroenterology Grand Rounds, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293
Hematology/Oncology Fellow's Forum, Fridays, 8:15 a.m., ACRC Betsy Blass conference room
LR Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC conference room 3 times a month, CARTI Auditorium once a month
LR Vascular Conference, time & date varies monthly, rotates between UAMS, SVI & BMC
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B
Med/Path Conference, third or fourth Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306
Medicine Research Conference, three Wednesdays a month, 4:30 p.m. UAMS Education Bldg. room B/135
Neurology Clinical Case Conference, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH
Neuropathology Conference, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Ob/Gyn Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours
Orthopaedic Basic Science Conference, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135
Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
Surgery Basic Sciences Conference, first Saturday, 7:30 a.m., ACRC 2nd floor conference room
Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room
Surgery Morbidity & Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room
Surgery Resident Case Conference, second, third, fourth, fifth Saturday, 7:30 a.m., ACRC 2nd floor conference room
Trauma Morbidity & Mortality Conference, date & time varies monthly, ACRC 2nd floor conference room
VA Chest Conference (combined Surgical/Medical Chest Conference), Mondays, 12:15 p.m., VAMC-LR, room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173
VA GREEC/Geriatric Research Conference, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109
VA Hematology/Oncology Conference, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142
VA Lung Cancer Conference, Thursdays, 3:00 p.m., VAMC-LR, room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130
VA Medicine-Pathology Conference, Tuesday, 2:00 p.m., VAMC-LR, room 2D109
VA Medicine Resident's Clinical Case Conference, Fridays, 12:00 noon, VAMC-LR, room 2D08
VA Physical Medicine & Rehab Grand Rounds, fourth Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine Conference, second, third, & fourth Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118
VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology conference room

EL DORADO - AHEC

Behavioral Sciences Conference, first & fourth Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, second Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second & fourth Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, fourth Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, first, second & third Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

Behavioral Sciences Conference, third Wednesday, 12:00 noon, Washington Regional Medical Center
City Hospital Staff Medical Meeting, second Friday, 12:00 noon, Fayetteville City Hospital
Family Medicine Conference, first, third, fourth Thursday; fourth Wednesday; second Thursday (odd months) AHEC-NW
Interesting Case Conference, 1st & 3rd Friday, 12:00 noon, Fayetteville City Hospital
Medicine Conference, first & third Tuesday, 12:00 noon, Washington Regional Medical Center
OB/GYN Conference, April 11, 12:00 noon, AHEC conference room
Pediatric Conference, second Wednesday, 12:00 noon, Washington Regional Medical Center
Radiology Conferenc, April 3, 12:00 noon, Washington Regional Medical Center
Surgery Conference, second Tuesday, 12:00 noon, Washington Regional Medical Center Fulbright Board room

FORT SMITH - AHEC

Internal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center

Neuroradiology Conference, third Wednesday, 12:00 noon, St. Edward Mercy Medical Center
Pediatric Cardiology, November 21, 12:00 noon, Sparks Regional Medical Center, 7th floor dining room
Issues in Ventilator Weaning, November 28, 12:00 noon, Sparks Regional Medical Center, 7th floor dining room

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first & third Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.
Chest Conference, second Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided
Craighead/Poinsett Medical Society, first Tuesday, 7:00 p.m. Jonesboro Country Club
Eaker AFB CME Conference, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria
Independence County Medical Society, second Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, fourth & fifth Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.
Jackson County Medical Society, third Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, third Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, second Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neuroradiology Conference, third Friday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided.
Pocahontas CME Conference, third Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom
Tumor Conference, 2nd Thursday, 4th Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided
Walnut Ridge CME Conference, third & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

PINE BLUFF-AHEC

Behavioral Science Conference, first & third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second & fourth Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, first & fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, second & fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second & fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates from St. Michael Hospital & Wadley Regional Medical Center
Neuro-Radiology Conference, first & third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st through 4th Friday, 12:00 noon, alternates from Wadley Regional Medical Center & St. Michael Hospital

AMS Directory Update

Please be watching for your Type of Practice (TOP) informational sheet around the end of March. This information is used for the 1991 AMS Membership Directory.

Please return your TOP to the Society office as soon as possible.

Arkansas Medical Society
P.O. Box 5776
Little Rock, Arkansas 72215

YOCON®

YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

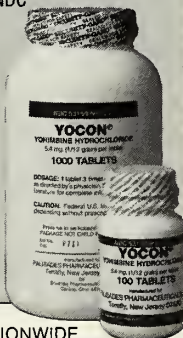
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

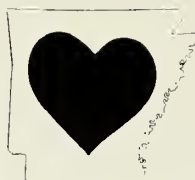
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Family Medicine Faculty, Assistant or Associate Professor. Community-based, twelve resident program with university affiliation. Five full-time physician faculty members. Responsibilities include teaching and supervision of residents and medical students, four half days of patient care per week, and research if desired. Obstetrical skills essential. Fayetteville is the location of the main campus of University of Arkansas and is situated in the beautiful Ozark Mountains. School system and economy are considered the strongest in the state. Salary very competitive.

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241 West Spring, Fayetteville, AR 72701
(501) 521-0263.

Health Access America

The AMA proposal to
improve access to affordable,
quality health care.

“I can’t afford to go to the doctor.”

We hear that a lot from our patients these days. For the 33 million people who have no health insurance, it’s a particularly acute problem.

That’s why the AMA has launched a proposal to improve access to affordable, quality health care. It’s called *Health Access America*. The message is being sent to Congress, the media, labor and management organizations, concerned groups like AARP, and your fellow physicians.

Simply, *Health Access America* proposes health insurance coverage

for all Americans, regardless of income or health status. It calls for expanded publicly-funded health care for the needy; a stronger Medicare system; employer-provided coverage for all workers and their families with tax incentives for small businesses.

America’s physicians are leading the way to reforming the health care system by speaking out on these critical issues.

To get a copy of the *Health Access America* proposal, please call our Member Service Center at 1-800-AMA-3211.

The American Medical Association
on behalf of member physicians and their patients.





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Part-Time Medical Consultant

The Arkansas Disability Determination for Social Security Administration is seeking a Pediatrician to work part-time as a Medical Consultant to evaluate medical evidence pursuant to Social Security laws and regulations. The salary range is \$46.00 to \$48.00 an hour.

Please send resume by March 31, 1991 to:

Carolyn J. Davis
Personnel/Medical Relations Manager
Disability Determination for Social Security Administration
701 Pulaski Street
Little Rock, Arkansas 72201

Position: Second Year PGY II

July 1, 1991: PGY II Family Practice Resident Position.

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UAMS - Area Health Education Center
100 South 14th Street
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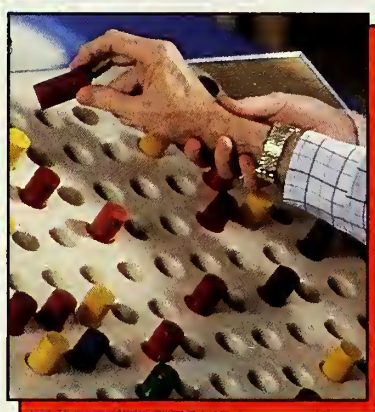
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Volume 87 Number 11

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THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

Volume 87 Number 11

April 1991

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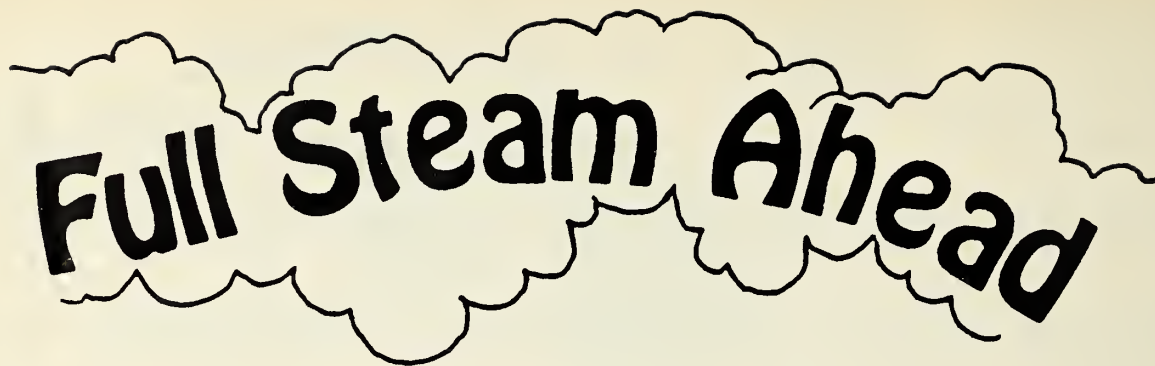
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Cover photo provided by the Arkansas Department of Parks & Tourism



Arkansas Medical Society Convention Program

115th Annual Session

April 25-27, 1991

Arlington Hotel and Exhibit Center
Hot Springs, Arkansas

Thursday, April 25, 1991 _____

Friday, April 26, 1991 _____

10:00 a.m.

Golf and Tennis Tournaments

Hot Springs Country Club - Participants must pre-register.

1:00 p.m. - 5:00 p.m.

Registration

Mezzanine

3:00 p.m. - 4:45 p.m.

Council Meeting

4:00 p.m. - 6:00 p.m.

Early Arrival Hospitality Suite

AMS members, spouses, and exhibitors invited.
Sponsored in part by M.A.D.D.

5:00 p.m.

House of Delegates

Conference Center B. Keynote address:
John L. Clowe, M.D.
Speaker, AMA House of Delegates
Schenectady, New York

7:00 p.m. - 8:30 p.m.

Blue Cross Blue Shield Reception

Ballroom

7:30 a.m. - 5:00 p.m.

Registration

Mezzanine

8:00 a.m. - 10:30 a.m.

Reference Committee Meetings

8:30 a.m. - 10:30 a.m.

Continental Breakfast

Exhibit Center - Exhibit Area Open
Sponsored by Continental Medical Systems:
Northeast Arkansas Rehabilitation Hospital
Central Arkansas Rehabilitation Hospital

10:30 a.m. - 11:45 a.m.

First Feature Session

Conference Center B - Keynote address:
"Medicare Frustrations, A Doctor Fights Back"
John Ebensberger, M.D., Greene, Iowa
Tim J. Gibson, Director of Public Affairs and Medical
Services, Iowa Medical Society

12:00 noon - 1:30 p.m.

Shuffield Lecture and Luncheon

Ballroom - Recognition of Shuffield Award Winner.
The Honorable William E. Dannenmeyer
U.S. Representative, California

1:45 p.m. - 2:45 p.m.

Second Feature Session

Conference Center B - Keynote address:

"Improving Access to Health Care Through Medicaid"

Terry Yamauchi, Director

Department of Health and Human Services

Kenny Whitlock, Deputy Director

Department of Health and Human Services

3:00 p.m. - 5:00 p.m.

Exhibit Center Open

Nickel Beer & Popcorn

Sponsored in part by Allen and Hanburys

3:45 p.m.

Council Meeting

6:00 p.m. - 8:30 p.m.

Riverboat Reception Cruise

Belle of Hot Springs

Hosted by The Medical Protective Company

Saturday, April 27, 1991_____

7:30 a.m. - 4:00 p.m.

Registration Open

Mezzanine

8:00 a.m.

MED-PAC Breakfast

Honoring MED-PAC contributors

Sponsored by Arkansas Regional Organ Recovery Agency

9:00 a.m. - 10:30 a.m.

Third Feature Session

Conference Center B - Keynote address:

"The Doctor has AIDS: A Patient's Right to Know"

Daniel Seckinger III, M.D.

Miami, Florida

10:30 a.m.

Exhibit Center Open

Brunch

Sponsored by James Foss and Associates

12:00 noon

Fifty Year Club Luncheon

Honoring AMS Fifty Year Club Members.

12:45 p.m.

Grand Prize Drawing

Exhibit Center - Grand Prize: Cancun Mexico. Stay in a five star hotel for 3 nights and 4 days. Donated by Tours and Travel, Russellville, AR. Must be present to win.

1:00 p.m.

AIDS Seminar

Conference Center B - Keynote address:

"HIV: Health Care Worker Issues"

Julie Gerberding, M.D., Director

HIV Counseling and Testing Services

San Francisco General Hospital

1:00 p.m.

Specialty Meetings

Arkansas Academy of Family Physicians

Arkansas Orthopaedic Society

Arkansas Pathology Society

Arkansas Psychiatric Society

Arkansas Society of Plastic and Reconstructive Surgeons

Arkansas Chapter, American College of Radiology

Arkansas Urologic Society

3:30 p.m.

Memorial Service

Honoring members of the Society and Auxiliary who have died during the past year.

4:00 p.m.

House of Delegates

Conference Center B

7:00 p.m.

Inaugural Banquet

Ballroom

George Warren, M.D., will be installed as the 1991-1992 AMS President

Master of ceremonies: William N. Jones, M.D. 1990-1991 AMS President

Entertainment: Doc Blakely

Humorist, CPAE, author

Sponsored by State Volunteer Mutual Insurance Company

Sunday, April 28, 1991_____

8:30 a.m.

Past Presidents Breakfast

Honoring AMS Past Presidents

Targeting Volunteerism and Building Community Partnerships

Arkansas Medical Society Auxiliary

67th Annual Session

April 25-27, 1991

The Arlington Hotel

Hot Springs, Arkansas

Registration _____

Mezzanine

Thursday 1:00 p.m. - 5:00 p.m.

Friday 7:30 a.m. - 5:00 p.m.

Saturday 7:30 a.m. - 4:00 p.m.

Official honorary hostesses for the 67th Annual Session are past presidents of the Arkansas Medical Society Auxiliary.

Thursday, April 25, 1991 _____

10:00 a.m. - 3:00 p.m.

Arkansas Leadership Confluence for State and County Officers

(Arrangements are being made by Mrs. Charles Rodgers, President-elect; details announced later)

3:00 p.m.

Pre-Convention Board Meeting

Magnolia Room - All State Officers, State Committee Chairmen, County Presidents, County President-elects, and Past State Presidents. All new Board members for 1991-92 are cordially invited to attend.

7:00 p.m.

Blue Cross Blue Shield Reception

Friday, April 26, 1991 _____

8:00 a.m.

Continental Breakfast

Magnolia Room - Members and guests are invited.

8:30 a.m.

"Arkansas Adolescent and Teen Health Concerns"

Joycelyn Elders, M.D., Director
Arkansas Department of Health

9:30 a.m.

Opening General Session

Magnolia Room - Mrs. David Williams, President, presiding

General Business, Roll Call, and Seating of County Delegates

Introduction of Special Guests:

Mrs. Joe Ed Smith
Mrs. William D. Shelton
John Lee Clowe, M.D.
William Jones, M.D.
Mr. Ken LaMastus
Ms. Peggy Pryor Cryer

Address:

Mrs. Joe Ed Smith
Director, Southern Region
American Medical
Association Auxiliary



Mrs. Joe Ed Smith

Convention Announcements:

Mrs. Cecil Cupp, Convention Chairman

Reports of Officers and

Committee Chairmen

Unfinished Business

New Business

Election of the Nominating Committee

(2 from the Board; 2 from the House of Delegates)

Election of Delegates and Alternates to the 1991 American Medical Association Auxiliary Convention.

Presentation of the 1991-92 Budget:

Mrs. Jim Garner, Finance Chairman

Adjournment

12:00 noon

Shuffield Lecture and Luncheon

Ballroom - Recognition of Award Winner
The Honorable William E. Dannenmeyer
U.S. Representative, California

2:00 p.m.

Historic Downtown Walking Tour

Tour art galleries and antique shops. Pre-arranged facial or bath massage at the Arlington Hotel.

4:00 p.m.

Afternoon Tea

Historic Stitt House Restaurant

6:00 p.m.

Riverboat Reception Cruise

Belle of Hot Springs

Saturday, April 27, 1991 _____

8:00 a.m.

Past Presidents' Breakfast

Fountain Room

8:15 a.m.

Continental Breakfast

Magnolia Room - Members and Guests

8:45 a.m.

"Health Youth 2000"

Arvil Burks, Ed.D.

University of Central Arkansas, Conway

Gary Parish, Program Advisor

Comprehensive School Health

State Department of Education

9:30 a.m.

Second General Session

Magnolia Room

Mrs. David Williams,

President, Presiding

General Business

Greetings from Southern:

Mrs. William D. Shelton,

President-elect

Southern Medical

Association Auxiliary

Reports by County Presidents:

Moderators: District Vice Presidents

Northeast: Mrs. Don Vollman

Northwest: Mrs. Robert P. Hughes

Southeast: Mrs. David Jacks

Southwest: Mrs. Dale Kincheloe

Unfinished Business

New Business

Nominating Committee Report: Mrs. Larry Lawson

Election of Officers

Adjournment

12:15 p.m.

Luncheon

Majestic Hotel, Grady Manning Dining Room

Hostess: Pulaski County

Invocation

Presiding: Mrs. David Williams, President

Introduction of Guests

Presentation of Awards:

AMA-ERF:

Mrs. Jerry Holton, Chairman

Vinne E. Garrison Memorial Award:

Mrs. Joe Crumpler, Chairman

Membership Award:

Mrs. Charles Rodgers, Chairman

Doctors' Day Award:

Mrs. David Jacks, Southern Medical Auxiliary
Councilor

Installation of Officers:

Mrs. Joe Ed Smith, Director, Southern Region
American Medical Association Auxiliary

2:30 p.m.

Post Convention Board Meeting

Majestic Hotel

3:45 p.m.

Memorial Service

7:00 p.m.

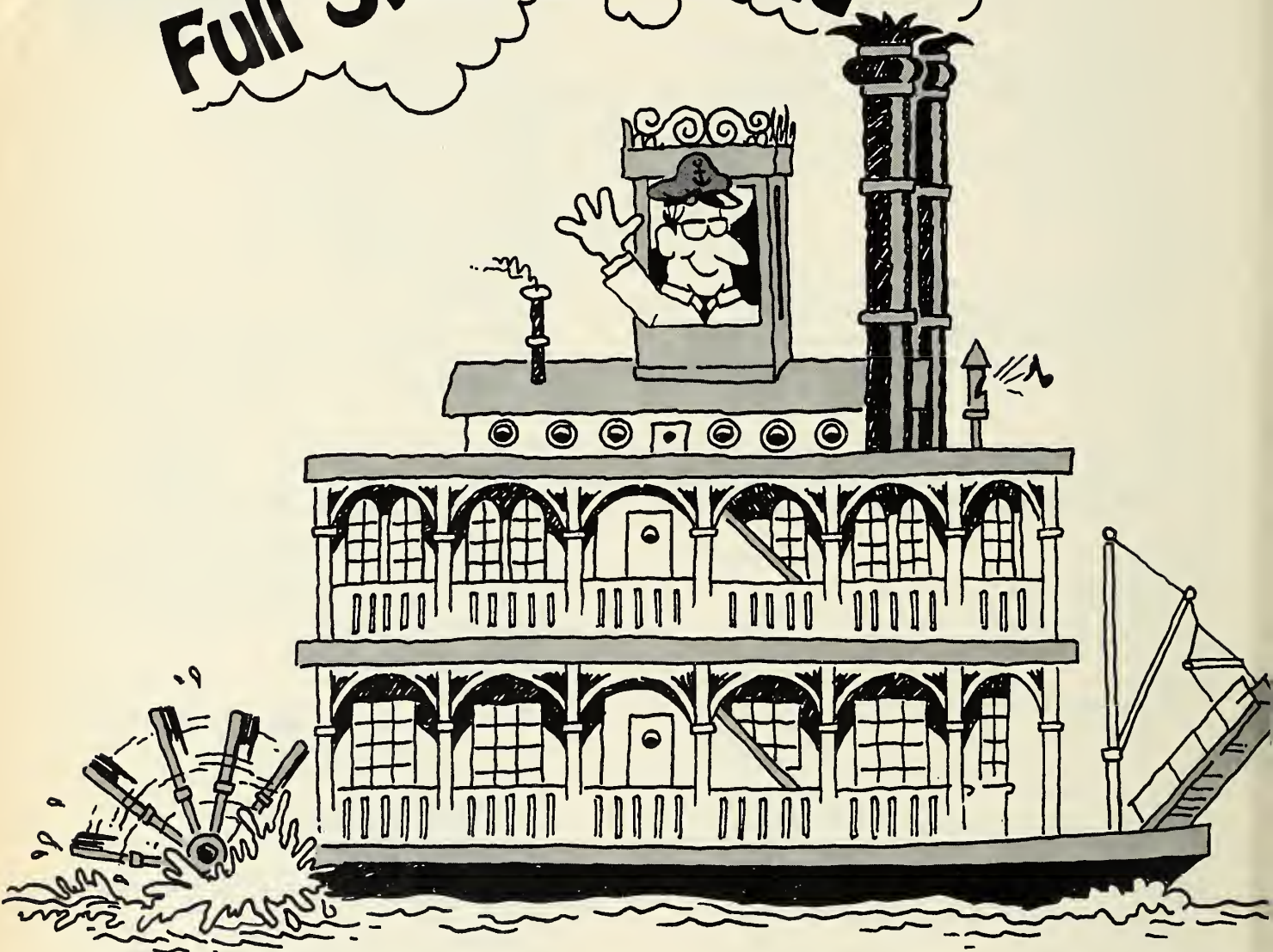
Inaugural Banquet

Ballroom



Mrs. William D. Shelton

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**Arkansas Medical Society
115th Annual Session
Hot Springs, Arkansas
April 25 - 27, 1991**

Convention Registration Form



Dr. _____
(Please Print)

Mr./Mrs. _____
(First and Last Name)

Title _____
(Delegate, Officer, Councilor)

Specialty _____

Address _____

City _____ State _____ Zip _____ County _____

Registration Information

AMS Member and Spouse fees cover the Shuffield Luncheon, Inaugural Banquet, Exhibit Center Continental Breakfast, Exhibit Center Brunch, and entrance into the Exhibit Center.

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The Rural Health Issue

Ben N. Saltzman, M.D.

Today, in Arkansas, as well as in many other rural states the cry is heard, "Our small hospital is closing. How can we keep our doctors?" Our rural citizens are not alone in the fear that they will be deprived of good health care. The media proclaims that our legislature, our governor and even the President of the United States are concerned. Good health care for the rural communities has always been a problem. Today, once again, medical societies are forming rural health committees to study a problem that has been studied to death.

I recall vividly my arrival in 1946 in the small Arkansas town of Mountain Home situated in the foothills of the Ozark Mountains. Following active duty as a medical officer in World War II, I began the practice of general medicine. There was no hospital. The streets were unpaved. The roads were dirt, rocks, and gravel. House calls were standard and deliveries were accomplished in the homes. The end of World War II brought with it a population explosion as well as a burgeoning obstetrical practice.

With the acquisition of a partner some three years later, I sought some answers to the problem of inadequate medical care. I was appointed to the Rural Health Committee of the Arkansas Medical Society and became interested enough to attend the National Rural Health Conferences of the American Medical Association. The conferences were sponsored by the Council on Rural Health of the AMA. The members of the Council were knowledgeable physicians who knew the problems and sought experienced practitioners to present at the conferences. I learned a great deal at these meetings and put what I learned into practice. I found that it was possible to practice good general medicine on an ambulatory basis. The medical school in Little Rock was a good source for referrals and for recommendations to practicing tertiary care physicians. It was possible to practice a better form of obstetrics by bringing patients to my office for delivery and an overnight stay. Ambulatory obstetrics made sense even in those days.

However, the need for a hospital was uppermost in my mind. The community was not interested in financing a hospital and suggested that if I wanted one, I could build it myself. I wanted one very badly. So I started with a seven-bed unit that rapidly grew into 27 beds. More physicians came into the community with the facilities available and the town began to flourish. Soon it was apparent that we needed bigger and better facilities. Some members of the Chamber

of Commerce asked me to head a steering committee to construct a larger community owned hospital. We opened with a 43-bed unit about 28 years ago. Today, the Baxter Regional Hospital has 150 beds and needs more. From my early days as the lone practicing physician in the community, the practicing physician population of Mountain Home has grown to more than 50.

It was not my work as a physician that accounted for the progress in health care. It was the work of the city council and the Chamber of Commerce, and of the stick-to-itiveness of the people who had pride in their community and were willing to work for progress.

In 1960, I was appointed to the AMA Council on Rural Health and served 10 years, two of those as chairman. Arkansas's committee held numerous conferences over the year. We employed the strategies we learned nationally. We formed liaisons with the Cooperative Extension Service, the Farm Bureau, the Arkansas Dental Association, Arkansas Power & Light Company, the auxiliaries of the medical and dental societies, the PTA, and the County Judges. We involved the people of rural communities and they worked together.

Progress was being made in Arkansas. The Dean of the Arkansas College of Medicine, Thomas A. Bruce, M.D., took an active interest in trying to increase the number of medical students who would be interested in practicing in rural communities. The AHEC programs were initiated for the state. A rural medical development program was instituted to expose students to rural communities and "Opportunity Days" were established to bring citizens of interested communities to the medical center to expose them to the students. In 1984, Dr. Bruce and W. Richard Norton published an excellent book entitled, "Improving Rural Health: Initiatives of an Academic Medical Center." In this book, he addressed the efforts made by the medical college to do just that. A great deal has been written.

My purpose in writing this editorial is to encourage those studying the rural health problem to read what has gone before and not "reinvent the wheel." A recent study by the Rural Health Committee of the American Public Health Association determined that the chief rural health problem in the minds of Health users and providers is access to health care. Perhaps more physician-owned ambulatory centers is the answer. The public liked the idea in the old days.

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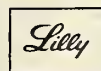
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- an information exchange on PRO and Managed Care Review;
- AMA-HMSS Governing Council elections for the positions of Delegate, Alternate Delegate and one Member-At-Large.

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HMSS

Variations in Utilization of Carotid Endarterectomy in Arkansas

Results of a Small Area Analysis Educational Feedback Pilot*

Arkansas Medical Assessment Pilot Project Study Group on Carotid Endarterectomy**

Variations in utilization of health care resources have been established for a number of medical conditions.¹⁻⁵ Small area analysis (SmAA), originally described by Wennberg⁶ and Gittelsohn, is a technique to quantify the variance in utilization of health services. This technique involves analysis of modified DRG codes of claims data for Medicare patients of specific clusters of contiguous residential zip codes, representing so called hospital market areas (HMAs) in a given state. When physicians confer to address reasons for variations in utilization of health care delivery, the subsequent variability in the use of these resources frequently decreases, often with concomitant improvement in the delivery of care and reduction in health care expenditures.¹ As a consequence, the Health Care Financing Administration (HCFA) initiated a proposal to establish projects with selected states to carry out SmAA with the support of the state Peer Review Organizations (PROs). The objectives of the proposal were threefold: 1) to initiate studies of SmAA to investigate the reasons for variations in utilization of health care resources, 2) through physician feedback to reduce the magnitude in variations of health care utilization; and 3) to foster the constructive interaction between physicians and their state PRO. Arkansas was chosen as one of 12 states to participate in this pilot project. This report reviews

the preliminary results for this effort which addressed the variation in utilization of carotid endarterectomy in Arkansas.

Section of Study Group Condition

Carotid endarterectomy was selected as the medical condition for review for the following reasons:

1. This operation is commonly performed, being second only to coronary artery bypass as the most frequent cardiovascular procedure.
2. The efficacy of the procedure, relative to medical therapy, has been questioned.
3. Variations in utilization of this procedure have been documented by the RAND Study.⁴
4. The frequency of performance of this procedure has declined in recent years.
5. Arkansas leads the nation in stroke-related deaths.⁷
6. Carotid endarterectomy has been an area of professional academic interest of the study group leader.

Selection of Study Group Members

Dr. Barnes was asked by the staff of our state PRO, the Arkansas Foundation for Medical Care (AFMC), to chair the study group. After being apprised of the HMAs in Arkansas which represented areas of high, average, and low utilization of carotid endarterectomy, Dr. Barnes contacted surgeons known to him from each of these areas who might be willing to serve on the study group. These individuals represented the disciplines of general, vascular and neurological surgery, along with a neurologist. All expressed enthusiasm for the project and agreed to serve on the study group.

* From the Department of Surgery, University of Arkansas for Medical Sciences, Little Rock; the Arkansas Foundation for Medical Care, Fort Smith; and the American Medical Review Research Center, Washington, D.C.

Study group members: Robert W. Barnes, M.D., chairman, Alan Gocio, M.D., Ray Jouett, M.D., John Lambert, M.D., Dennis Lucy, M.D., Robert A. Petrino, M.D., George V. Roberson, M.D., Porter R. Rodgers, M.D., William R. Scurlock, M.D.

AFMC Staff: Russell Brasher, Ph.D., project team leader; J. David Busby, M.D., consulting physician; Donna Didier, M.Ed., R.R.A., education coordinator; and Gordon W. McCraw, M.D., physician director.

Principal Investigator: The American Medical Review Research Center.

Supported by funds from the Health Care Financing Administration, Department of Health, Education and Welfare, Washington, D.C.

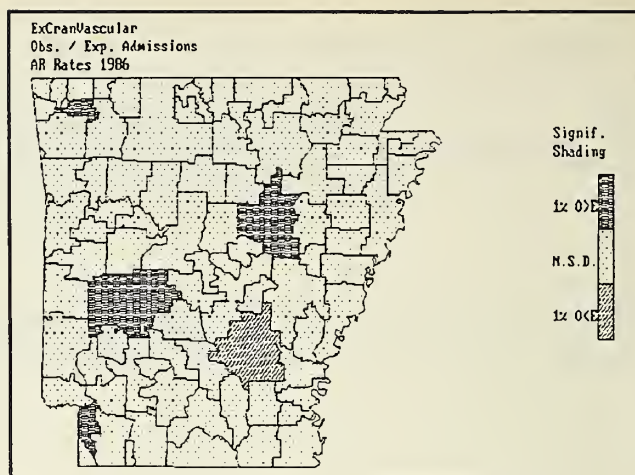
Objectives of the Study

The study group addressed the following objectives during two separate half-day meetings in Little Rock during the fall of 1989:

1. Review of the variations in utilization of carotid endarterectomy in Arkansas for the years of 1984-86 based on Medicare claims data from modified DRGs provided in software by contract with HCFA (SAM-GRAPH, Codman Research Group).
2. Review of the variations in utilization of carotid endarterectomy in Arkansas for the years 1987-88 based on data from the AFMC. These data were requested in order to identify any change in utilization that might parallel the national trend toward reduction in performance of this operation in recent years.
3. Review of the impact, if any, of the institution of the AFMC pre-certification program for carotid endarterectomy on the utilization of carotid endarterectomy in Arkansas.
4. Evaluate variables that might explain the variation in utilization of carotid endarterectomy in Arkansas.
5. Develop a strategy for feedback to physicians in Arkansas of information derived from this study in order to reduce variations in utilization of carotid endarterectomy and, hopefully, improve to health care delivery.
6. Design future studies to investigate reasons for variations in utilization of carotid endarterectomy in Arkansas.
7. Prepare a consensus report, as requested, for delivery to the American Medical Review Research Center (AMRRC), which contracted to carry out the pilot studies of small area analysis for HCFA.

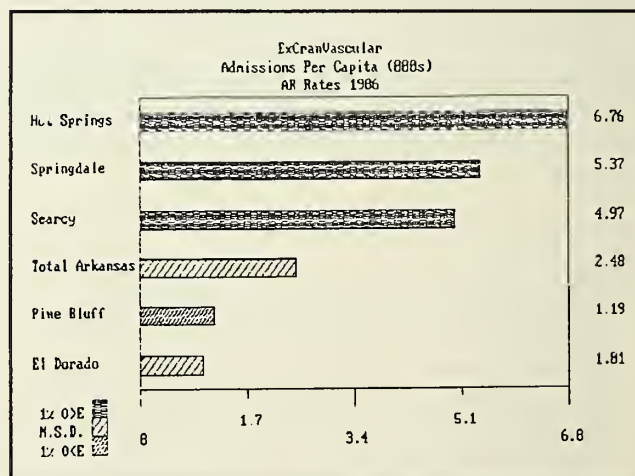
Variations in Utilization of Carotid Endarterectomy in Arkansas

Figure 1 shows a map of Arkansas which depicts HMAs with significantly high, average, and low rates (at 1% confidence levels) of utilization of carotid endarterectomy in Medicare patients for the year 1986. The study group did not evaluate data for the border cities of Fort Smith, Texarkana, and West Memphis because of the ambiguity of which state might provide health care delivery for the population in those areas. Figure 2 depicts the age-adjusted admission rates per thousand for utilization of carotid endarterectomy for different Arkansas HMAs and the average for Arkansas for 1986. There was a sixfold difference between the high use and low use areas. The overall state rate of utilization of carotid



endarterectomy, 2.48 per thousand, was significantly higher than that for the nation, 1.63 per thousand. The rate of utilization of carotid endarterectomy in the low use areas of Arkansas did not differ significantly from that of the nation. Figures 3 and 4 show the ratio between the observed and expected rates of hospital admission of Medicare patients with modified DRGs representing cerebral transient ischemic attacks (TIAs) and stroke, respectively, for the high, average, and low use HMAs in Arkansas for the year 1986.

The utilization of carotid endarterectomy in the high use HMAs of Arkansas reached a peak in 1986 and steadily declined in 1987 and 1988. The utilization in the low use HMAs declined in 1985 and 1986 and then increased in 1987 and 1988, although remaining significantly below the high use areas. The institution of the AFMC pre-certification criteria for carotid endarterectomy in April 1989 did not appear to influence the rate of utilization of carotid endarterectomy.

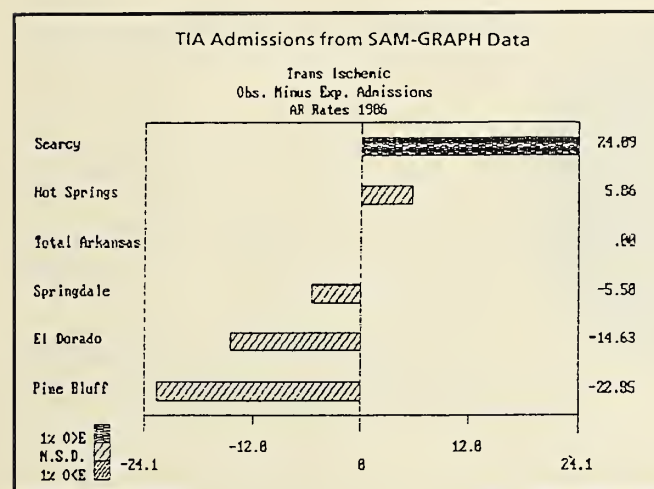


Variables Influencing Utilization of Carotid Endarterectomy

The study group reviewed a number of factors which might affect the variance in carotid endarterectomy in differ-

ent HMAs of Arkansas. These variables included those related to the population at risk, resource availability, and differences among physicians attitudes and practice patterns.

Population variables that were evaluated included age, race, and prevalence of extracranial carotid disease. The small area analysis statistics were adjusted for age. Although Arkansas is second only to Florida in retirees per capita, differences in mean age and age distribution for different HMAs could not explain the variability in utilization of carotid endarterectomy. Racial demographics vary in different parts of the state. Some population-based studies have



suggested that whites have a higher prevalence of extracranial carotid occlusive disease than blacks, whereas the latter suffer higher rates of stroke due to hypertension or intracranial disease.^{8,9} Although claims data do not provide information on race, review of state mapping of racial demographics in Arkansas did not explain differences in performance of carotid endarterectomy. Finally, no population-based data are available to determine if the prevalence of extracranial carotid occlusive disease varies in different HMAs in our state.

The study group investigated the possible correlation of increased utilization of carotid endarterectomy with the availability of noninvasive diagnostic technology to detect extracranial carotid disease. Review of third-party claims data for the frequency of noninvasive cerebrovascular testing failed to correlate with the number of carotid endarterectomies performed in a given HMA.

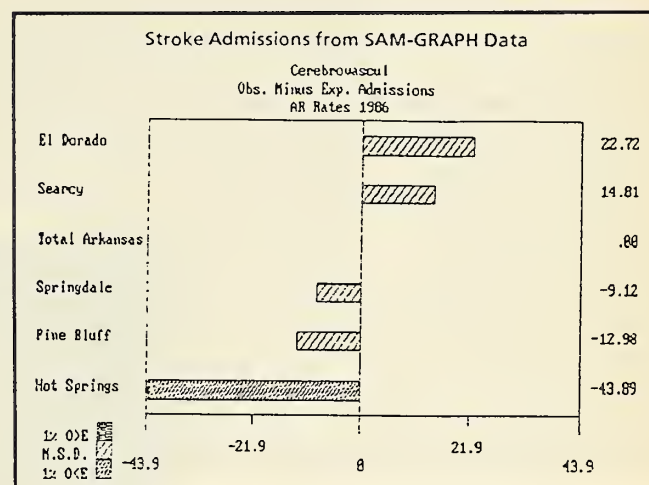
Physician practice variables were considered to be the most likely explanation for differences in utilization of carotid endarterectomy. This has been inferred by the studies reported by the RAND Corporation.⁴ The study group members were given a multiple-choice questionnaire about management options for a variety of patient conditions related to symptomatic and asymptomatic cerebrovascular disease. These questions were patterned after hypothetical clinical problems addressed by the RAND study panel of consultants. Although there was some variance among our

study group members, most shared similar views about patient management. This congruence of attitudes may reflect the knowledge of precertification criteria for carotid endarterectomy initiated by the AFMC one year ago.

In final analysis, the study group on carotid endarterectomy did not find any single factor or combination of variables which could explain the differences in utilization of this operation in various HMAs of Arkansas. As in other groups studying small area analysis, differences of physician practice patterns were considered the most likely explanation of variations in performance of carotid endarterectomy in our state. It was the consensus of the study group that additional information was necessary to reach a conclusion about the practice variability of this operation in Arkansas. The group felt it was particularly important to sample the hospital medical records in different HMAs to define the indications for, and short-term outcomes of, carotid endarterectomy in our region.

Future Directions

The study group discussed strategies for further investigation of variations in utilization of carotid endarterectomy. These efforts could be grouped into three categories of activity: 1) feedback of information to appropriate practitioners and professional groups; 2) short-term research efforts to further sample hospital records for practice patterns and short-term outcomes; 3) long-term development of practice



guidelines and patient outcome monitoring. The need for securing funding for these endeavors was recognized.

Feedback strategies were an objective of the original charge to the study group. Previous investigations of variations in utilization of health services using the small area analysis concept have found that appropriate feedback to pertinent individual physicians and their professional societies will reduce practice variation and, by inference, improve health care delivery.¹⁻⁵ Our study group felt that initial

efforts at physician feedback could encompass four domains: 1) an announcement in the bulletin of the AFMC; 2) a general report at the Annual Session of the Arkansas Medical Society; 3) presentations at regional statewide meetings for appropriate surgical specialty societies (general or vascular surgery and neurologic surgery); and 4) a publication in *The Journal of the Arkansas Medical Society*. The first objective was published in the November 1989 issue of the *Physician News* of the AFMC.¹⁰ At the Annual Session of the Arkansas Medical Society in Hot Springs in May 3-5, 1990, the study group chairman reported to the Executive Council and a scientific exhibit portrayed the efforts of the study group on carotid endarterectomy. The study group activities were reported at the Annual Meeting of the Arkansas Chapter of the American College of Surgeons at Eden Isle on June 7-9, 1990 and at the state meeting of the Neurologic Surgeons at Eden Isle on September 7-9, 1990. This paper represents the first report of the study group deliberations in *The Journal of the Arkansas Medical Society*.

The study group plans to pursue two short-range projects for further investigation of the variability of carotid endarterectomy in our state. First, a pilot study has been initiated to determine the variability of interpretation of the severity of carotid stenosis on cerebral arteriograms. Second, a sample survey of, the indications for, and the short-term outcome of carotid endarterectomy will be carried out through a retrospective analysis of hospital records in various HMAs of high, average, and low utilization of carotid endarterectomy in Arkansas.

Our long-term goals are to use this preliminary information to generate pertinent practice guidelines and assessment strategies for short and long-term outcome analysis of the effects of carotid endarterectomy in our region. Because such efforts have assumed a national priority, we feel that these preliminary efforts will lead to more rational attempts to constructively modify practice patterns in favor of better patient outcomes that are both cost-effective and acceptable to practicing physicians. At the very least, the initial activities of the study group on carotid endarterectomy have led to improved understanding and creative cooperation between practicing surgeons and physicians and members of our state PRO, the AFMC. Such was the principal objective of this Federal initiative. Hopefully our initial efforts will lead to further productive efforts in health services research by practicing physicians and surgeons in Arkansas.

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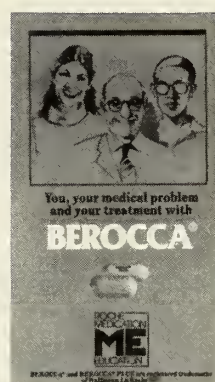


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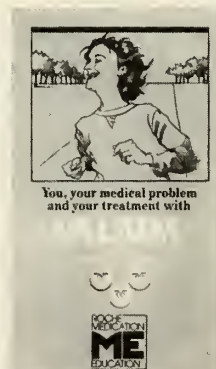
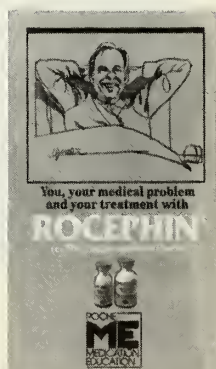
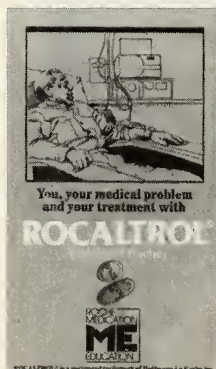
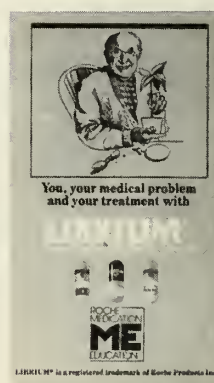
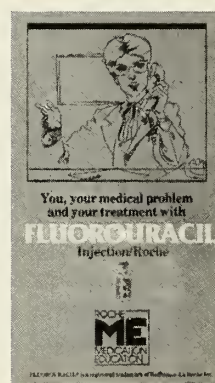
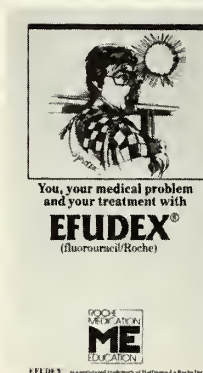
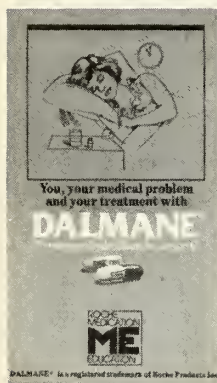


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Diagnosis and Treatment of Obstructive Sleep Apnea

Robert N. McGrew, M.D.*
Sharon S. Graham, M.S.

Sleep apnea is increasingly recognized as the basis for many sleep disturbances and other common symptoms such as enuresis and morning fatigue. Over the past 20 years, much as been learned about sleep disordered breathing, its etiology, epidemiology and pathophysiology, how it can be recognized, and what techniques are required for diagnosis and treatment.

Sleep apnea is defined as the cessation of air flow for at least 10 seconds during sleep. The sleep apnea syndrome is a disorder in which at least 30 episodes of apnea occur during seven hours of nocturnal sleep, or more than five episodes

The exact prevalence of sleep apnea is unknown but it is probably a common disorder, particularly in its milder forms. Many of these mild sleep apneas may go unrecognized even though they are associated with symptoms including hypersomnolence, snoring, startle arousal, hyperactivity, enuresis, restless sleep, failure to thrive, and impaired eating. It has been estimated that 1% of all adult men are afflicted with this disorder. There is a strong male predominance, and the majority of patients are over 40 years of age.¹ Additionally, there have been reports of up to a 5% incidence in the pediatric population.²

The variable respiratory drive of the central nervous system much be able to overcome the airway resistance continuously or else "respiratory pauses" (less than 10 seconds), "apnea" (greater than 10 seconds), or "hypopnea" (less than 1/3 of the basal air flow) occur. Anatomical risk factors may determine airway resistance in both the awake

Table 1
Symptoms of Obstructive Sleep Apnea (OSA)

Daytime somnolence	Hypertension
Snoring	Morning headaches
Restless sleep	Nocturnal Enuresis
Fatigue	

occur in any given hour.¹ The typical apneic episode lasts from 15-60 seconds and results in hypoxemia, hypercarbia, systemic and pulmonary hypertension, and bradycardia. If sleep apnea is associated with an upper airway obstruction as evidenced by continued ventilatory effort during the apneic interval, it is termed "obstructive sleep apnea." The assumption has been made that the lack of neuromotor ventilatory effort during the 10 seconds of apnea indicates a central cause; this may not always be true since the central respiratory drive has a variable period of latency which may exceed 10 seconds.

Table 2
Example Physical Findings in OSA

Obesity somnolence	Soft palate obstruction
Inattentiveness	Subglottic stenosis/mass
Mouth breathing	Large tongue
Septal deformity	Small mandible
Turbinate enlargement	Hypopharyngeal mass
Extrinsic pressure distortion pharynx, larynx or trachea	Vocal cord paralysis
Nasopharyngeal mass/deformity	Laryngeal lesion

state and in the relaxed state. Since upper airway resistance is dynamic and dependent on neuromotor tone, the relaxation of REM sleep, or stage 3 or 4 sleep may permit a partial obstruction to become a complete obstruction. The work of breathing may therefore exceed the individual's power for

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brief intervals at first resulting in their arousal and opening of the airway. In more severe situations, the interval may lengthen until serious levels of oxygen desaturation occur (PO_2 less than 50) and hypercarbia occur (PCO_2 greater than 45); these situations are capable of inducing arrhythmias and death in susceptible individuals. The upper airway is partly rigid and partly collapsible and thus subject to postural, gravitational, and extrinsic pressure influences.

Table 3
Nasal Causes of OSA

Septal deviation	Strictures
Foreign body/neoplasm	Cysts
Turbinate hypertrophy	Alar collapse
Chronic rhinosinusitis	Valve area closure
Choanal stenosis/atresia	Polyps

The pathophysiology of obstructive sleep apnea (OSA) is based on specific anatomic defects which determine the shape of the airway and thus airway resistance. Cranial nerve deficits can also alter the functional shape and resistance of the airways. The atony or atonia of sleep combined with the deforming forces of gravity alter the shape and lumen size, converting partial obstruction into complete obstruction. Although normal, the respiratory drive of the central nervous system may vary considerably in strength and be inadequate

Table 4
Nasopharyngeal causes of OSA

Adenoid hyperplasia
Lymphoma/tumors
Large soft palate and uvula
Glossopharyngeal nerve palsy

to overcome the obstruction. Neuromotor strengths may become inadequate as fatigue progresses.

In order to diagnose obstructive sleep apnea, the complete history is still of paramount importance. Symptoms which should alert the physician to the existence of OSA are listed in Table 1, while physical findings from the head and neck examination are seen in Table 2.

The history and physical examination are the least expensive and the most valuable part of the medical evaluation. Many different studies are needed to fully evaluate the airway. Anterior rhinoscopy, rhinometric flow pressure measurements with and without vasoconstricting spray, nasal endoscopy, direct and indirect naso- and hypopharyngo-

Table 5
Tongue-Base Causes of OSA

Obesity	Lingual thyroid
Macroglossia	Neoplasm
Mandibular hypoplasia	Mandibular fracture
Hypoglossal nerve palsy	Ludwig's angina
Lingual tonsillar hyperplasia	Parapharyngeal abscess
Thyroglossal cyst	

scopy, flexible endoscopy with Mueller's maneuver, polysomnography, cephalometric radiograph, axial CT scan, and somnofluoroscopy may all be considered. No one study is reliable in and of itself and should be interpreted only cautiously in light of other findings. Common laboratory data are moderately inexpensive to obtain and may be sufficient to confirm the seriousness of the diagnosis, i.e. enlarged heart by CXR, RVH, or strain by EKG, polycythemia by CBC, elevated bicarbonate, low PO_2 or high PCO_2 by the ABG's, etc. On the other hand, polysomnography is an expensive examination and is not always necessary for an accurate diagnosis of serious upper airway obstruction.³

The medical examination may reveal a number of causes of obstructive apnea. In children, obstructing adenoids and tonsillar hyperplasia are the most common cause of OSA.⁴ Other causes include craniofacial abnormalities such as mid-facial hypoplasia, macroglossia, choanal atresia, micrognathia, mandibular hypoplasia, laryngeal abnormalities and syndromes such as Down's, Hunter-Hurler's and Pierre Robin.⁵⁻⁷ In infants, esophageal reflux is a leading cause of OSA. Additionally, in toddlers, ingestion of foreign bodies, croup, and acute epiglottitis are important causes.

In adults, the causes of OSA can be classified by the anatomic level of obstruction, including nasal, nasopharyngeal, tongue base, and laryngeal sites. These causes are detailed by level of obstruction in Tables 3, 4, 5, and 6.

Intervention in obstructive sleep apnea may be a life saving procedure. Such intervention may reverse cor pulmonale and congestive heart failure.⁸ Such Intervention may prevent sudden death from arrhythmias or from falling asleep in precarious or potentially dangerous situations.

Table 6
Laryngeal Causes of OSA

Bilateral vocal cord paralysis
Laryngeal fracture
Tumor
Laryngocele
Subglottic stenosis
Papilloma

Table 8
Surgical Treatment of OSA

	General Success Rate	Morbidity
Gastric bypass	Fair	Significant
Nasal tip/valve surgery	Good	Low
Septoplasty/turbinate reduction	Excellent	Low
Endoscopic sinus surgery	Good	Low
Choanal repair	Good	Significant
Adenoidectomy	Excellent	Low
Tonsillectomy	Excellent	Significant
UVPP	Good	Significant
Tongue base procedure	Poor-Fair	Significant
Mandibular progression	Excellent	Significant
Tracheotomy	Excellent	Low

Treatment should not be delayed once the diagnosis is established.

Medical treatment regimens, their morbidity and general success rates are outlined in Table 7. The medical treatment of OSA, particularly in adults, may simply consist of weight reduction to alleviate the obstruction of the airway in obese individuals; however, compliance may be difficult. Continuous positive airway pressure (CPAP) delivers high air flow (20-45 liters per minute) at low pressure (4.5-10 centimeters H₂O) through a nasal or face mask to overcome extrinsic pharyngeal pressures, thereby lowering airway resistance.⁹ this is an effective short-term treatment in those

Table 7
Medical Treatment of OSA

	Pt. Compliance Tolerance	General Success Rate	Morbidity
Weight reduction	Poor	Excellent	Low
CPAP	Fair	Fair	Low
Protriptyline	Good	Poor	Low
Progesterone	Good	Poor	Low
Allergy Rx	Good	Good	Low

who tolerate it, but it has some complications, and the noise, restriction of motion and mask discomfort are problems for long-term use. Other non-surgical treatment has included Protriptyline, which is thought to reduce the amount of REM sleep. Progesterone has been used as a respiratory stimulant in the obesity-hypoventilation syndrome. Specific allergy immunotherapy and avoidance measures combined with intranasal steroid sprays have become an effective means of control of chronic nasal obstruction due to allergic rhinitis.

Surgical treatment of OSA, directed against the specific obstruction, is often the most definitive form of treatment. Associated morbidity and estimated rates of success for various procedures are listed in Table 8. The gastric bypass has been useful in achieving significant weight reduction in truly obese individuals. CPAP may be used to control OSA until the weight loss occurs. Nasal tip and valve surgery are effective at relieving anterior nasal obstruction. Septoplasty and turbinate reduction dependably reduce mid-nasal air resistance. Endoscopic sinus surgery has greatly improved the cure rate of chronic sinusitis, with more conservative and precise tissue removal.

Choanal atresia and stenosis repair is now a more reliable procedure due to better visualization by the nasal telescope and operating microscope. Adenoidectomy has long been an effective procedure for OSA due to obstructing adenoids. On the other hand, tonsillectomy and uvulopalatopharyngoplasty (UVPP) will dependably move the soft palate more anteriorly and inferiorly, and are highly successful. Of course, if inappropriately applied, these procedures will not relieve obstructions at other levels. Tongue-base reduction, hyoidopexy and midline tongue fillet resection effectively open the hypopharynx, but carry with them significant morbidity. Mandibular progression also is effective, but should only be offered to those patients with retrognathia or mandibular hypoplasia.¹⁰ Tracheotomy is highly dependable at controlling OSA but is not usually necessary for long-term management. Specific surgery for specific obstruction offers the best chance for cure of OSA.

All clinicians need to maintain a high index of suspicion to recognize OSA. Judgement should be exercised in selecting tests to prove the diagnosis while conserving patients' resources. The physician should carefully determine the level of obstruction so that therapy can be specific and accurate in removing that obstruction at that particular level. Over enthusiasm for a single procedure should be avoided. Additionally, it is important to remember to provide temporary care for patient safety. Once temporary care is instituted, arrangements can be made for definitive correction of the specific obstruction.

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Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the CNS and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

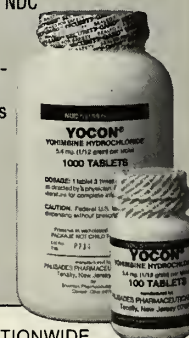
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., *New England Journal of Medicine*: 1221. November 12, 1981.
2. Goodman, Gilman — *The Pharmacological basis of Therapeutics* 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. *Weekly Urological Clinical letter*, 27:2, July 4, 1983.
4. A. Morales et al., *The Journal of Urology* 128: 45-47, 1982.

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Why Patients Sue Physicians

Scott Berglund*

Over the years, as I have asked physicians why they think a patient sues, I have most often been told it's because of the patient's financial incentive (but in words not so nice). This is not an unreasonable answer when one considers media hype of large jury awards and even the advertising campaigns of some malpractice insurance carriers. The fear of litigation is increasingly becoming a greater factor in the doctor's medical decisions.

There is certainly much more to the story, however. This article's title quote is an actual patient comment and is representative of a prevailing patient attitude. Many patients feel their doctor is not interested in them as people, but mainly as procedures to be performed. Whether or not this feeling is true does not matter so much as the fact that it is a common perception among patients.

Of additional interest are the statistics compiled in a survey of malpractice defense attorneys (remember they're the good guys).¹

Why Patients Turn Litigious

Provider Communications	35%
* failure to discuss and disclose	
* failure to respond to requests	
Provider Attitudes	35%
* in a hurry	
* air of superiority	
* appearing indifferent	
Unrealistic Expectations	5%
Provider Disparagement of Previous Care	7.5%
Media Coverage of Malpractice	7.5%
Patient's Financial Incentives	10%

Examination of these statistics reveals that in over 80% of the cases filed, action on the part of the patient is at least *triggered* by communication problems with the physician. This does not mean that the doctor is necessarily even "at fault" in these instances, but rather that the physician can have substantial influence upon the action the patient subsequently takes when an unfortunate outcome creates a potential problem. It is a matter of record that "bad doctors" do not always get sued and that "good doctors" do not always avoid trouble.

"He just wouldn't listen after it happened...he just didn't care."

In a significant number of instances, the physician can eliminate, or at least mitigate, the decision of the patient to pursue legal remedies. Of course, once a patient is in the domain of the plaintiff attorney things escalate rapidly. Resulting litigation or out of court settlements often do not reflect that malpractice actually occurred, but that a condition existed which made a jury award extremely likely. Physicians often consent to settle in cases where they felt they were not technically at fault.

The problem of defective doctor/patient rapport is a pernicious one, but not difficult to explain when one considers the training environment physicians live in from the time they enter medical school until they begin practice several years later. From the very beginning, doctors are the students of very strong personality types, other physicians who, especially in the beginning, treat medical students as subordinates who have nothing to contribute and are to do exactly

* Mr. Berglund is the risk management administrator at American Physicians Insurance Exchange.

as they are told. This environment may in fact be necessary, but as it progresses, medical students are not given ample opportunity to participate in two way communication or to build relationships. Unfortunately, many medical schools do not spend adequate time instructing doctors in the critical aspect of communication with the medical team and building relationships with patients.

Since the medical training environment is extremely stressful, both in medical school as well as intern and residency programs, the new doctor becomes adept at making decisions which do not often allow for open and timely communication. The new doctor can emerge from this process as a sole decision maker, who has been trained to take total responsibility for his or her patients and who tends, due to time and other stress factors, to overlook opportunities to communicate.

Other stressful professions have suffered as well from the lack of effective communications with others. Airline pilots, for instance, have also been trained to be "captains of the ship" and to take responsibility for crew behavior. In 1979, NASA produced a troubling report which found that approximately 80% of the near misses and fatal accidents in the commercial airline industry could not be directly traced to equipment failure, air-to-ground problems, lack of technical competence or a time factor. A case in point occurred in Alaska, where a commercial pilot discovered that the plane's landing gear light indicated that the gear was not down and locked. While the pilot and first officer tried to determine whether the gear was not down or whether the indicator light was faulty, they totally ignored the second officer's statements that fuel was becoming critically low, flying the plane eventually into the ground, killing everyone aboard. The black box showed that the second officer had been trying to communicate with the other team members for 15 minutes.

As a result of the NASA report, one airline began training its flight teams in team communication techniques. This training so positively affected the near miss and crash statistics that the airline's re-insurance carrier drastically reduced their premiums. Many other airlines have adopted this training procedure and have had similar results. The need to involve all team members in training of this type is very apparent, whether talking about cockpit crews or the medical team of doctor, patient, nurse and others. And although a doctor can never "suit proof" his or her practice, the potential for litigation can be significantly reduced.

What, then, can the doctor do to produce this reduction in exposure to suit by a patient? The answer revolves around the very important process of the improving communication in the medical arena. The following points bear careful consideration:

1. *The Doctor "Creates" the Patient.* Except in the case of emergencies, the physician establishes the relationship with the patient by taking the history, listening to the complaint and performing the examination. This provides with the opportunity to build a rapport which can

weather potentially serious challenges. Numerous instances can be cited where patients chose not to sue the doctor, even where a clear instance of misadventure or malpractice existed. The reason cited most often is the strong communication "bond" which was created between doctor and patient. This is certainly not to suggest creating such a relationship solely to avoid trouble, but to enhance the opportunity to create a treatment which is clearly understood and agreed upon, and which has the greatest chance of favorable results.

2. *An Angry Patient Is a "Dangerous" Patient.* It is human nature to avoid conflict. In doctor/patient relationships, however, this tendency can be disastrous. The physician must immediately seek to establish honest, caring and forbearing dialogue with the unhappy patient in order to effect a solution to the problem. That solution may be as simple as a more complete explanation of what happened, or it may result in some form of additional treatment to improve the condition. At least the physician has the opportunity to achieve a better outcome than litigation.
3. *Proper Informed Consent Is a Function of Shared Responsibility.* When the physician involves the patient in all phases of decision making, the result, whether optimal or unfortunate, is one the patient is much more willing to accept. The idea that informed consent revolves around the signing of a document giving permission for a procedure is extremely short-sighted. If the physician and patient have properly communicated about all phases of treatment, including potential positive and negative results and alternative treatments, and the patient has been treated as a valued contributor, the likelihood of future conflict is greatly reduced.
4. *Medical Team Communication Can Make or Break You.* The members of a doctor's medical can be his or her ally or downfall. Numerous suits are triggered by unrealistic or disparaging comments made by staff members, assistants, consultants or nurses. "You're taking *what* medication? That doesn't make sense." "I certainly don't agree with your doctors diagnosis." "Don't worry, doctor Jones has done a thousand of these procedures and nothing has ever gone wrong". Doctors are "set-up" every day by medical team members who, normally without malice, create a mind set in their patients which will predispose them to consider litigation when results other than the expected occur. It is critical for doctors to properly train their staff members in effective and accurate communication with patients, and to create with consulting physicians specific guidelines for handling consult situations. Physicians' disparaging remarks about each other count for a significant number of suits. Even where disagreement exists about diagnoses or procedures, there are ways of resolving such situations

without alarming patients and planting seeds of doubt or distrust.

We are imperfect people in an imperfect world. The fact that physicians are "only human" is often not fully accepted by the patient, however. This intolerance for error has been reinforced to a great extent by the significant advances in diagnostic and treatment procedures. The "Marcus Welby" image of medicine practice can be unintentionally portrayed by the physician who may be guilty of exhibiting a paternalistic demeanor in his or her desire to simplify decision making and engender trust in the patient. When things go awry, this portrayal backfires on the physician, who is extended no tolerance for unfortunate results.

In this age of rapid technological advances, the physician is hard-pressed to cope with the increasing pressure to practice "failsafe" medicine. As a risk prevention professional, I am often frustrated to review case after case where communication skills have not kept up with the technology

of medicine and have actually been the impetus for litigation. In the decade of the 90's, as expressed by James S. Todd, M.D., Vice President of the AMA, "No longer can we afford the broad-brush of risk prevention. It's time to get down into the doctor's office to where they live"². My risk management mission is to help our physicians see themselves as they are seen by their patients and to learn and implement risk prevention principles which will help avert occurrences which can be devastating both to the patient and the physician. As this occurs, doctors will be able to worry less about practicing defensive medicine. This will make the healing art more enjoyable to everyone concerned.

References

1. Conducted by State Volunteer Mutual Insurance Company, Brentwood, TN, 1986.
2. Physician Insurer, Vol. IV, Fourth Quarter, 1990.

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Contraindications: VASOTEC[®] (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: **Angioedema:** Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL) and/or measures necessary to ensure a patent airway, should be promptly provided.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, Drug Interactions and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Fetal/Neonatal Morbidity and Mortality: ACE inhibitors, including VASOTEC, can cause fetal and neonatal morbidity and mortality when administered to pregnant women.

Enalapril crosses the human placenta. When ACE inhibitors have been used during the second and third trimesters of pregnancy, there have been reports of hypotension, renal failure, skull hypoplasia, and/or death in the newborn. Oligohydramnios has also been reported, presumably representing decreased renal function in the fetus, limb contractures, craniofacial deformities, hypoplastic lung development and intrauterine growth retardation have been reported in association with oligohydramnios. Patients who do require ACE inhibitors during the second and third trimesters of pregnancy should be apprised of the potential hazards to the fetus, and frequent ultrasound examinations should be performed to look for oligohydramnios. If oligohydramnios is observed, VASOTEC should be discontinued unless it is considered life-saving for the mother.

Other potential risks to the fetus/neonate exposed to ACE inhibitors include: intrauterine growth retardation, prematurity, patent ductus arteriosus; fetal death has also been reported. It is not clear, however, whether these reported events are related to ACE inhibition or the underlying maternal disease. It is not known whether exposure limited to the first trimester can adversely affect fetal outcome.

Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion.

Enalapril has been removed from the neonatal circulation by peritoneal dialysis and theoretically may be removed by exchange transfusion, although there is no experience with the latter procedure.

There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril, but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day but not at 30 mg/kg/day (50 times the maximum human dose).

If VASOTEC is used during pregnancy or if the patient becomes pregnant while taking VASOTEC, the patient should be apprised of the potential hazards to the fetus.

Precautions: General: Impaired Renal Function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of Patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See Drug Interactions.)

Cough: Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients: Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of the face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If

actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions: Hypotension. Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC[®] (Enalapril Maleate, MSD) is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methylglucosides, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy: Pregnancy Category D. See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

Nursing Mothers: Enalapril and enalaprilat are detected in human milk in trace amounts. Caution should be exercised when VASOTEC is given to a nursing mother.

Lactation Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, Hypotension); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances including atrial tachycardia and bradycardia, atrial fibrillation; palpitation.

Digestive: Ileus, pancreatitis, hepatitis (hepatocellular [proven on rechallenge] or cholestatic jaundice), melena, anorexia, dyspepsia, constipation, glossitis, stomatitis, dry mouth.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, diaphoresis.

Special Senses: Blurred vision, taste alteration, anosmia, tinnitus, conjunctivitis, dry eyes, tearing.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION), impotence.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgia, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Fetal/Neonatal Morbidity and Mortality: In infants exposed *in utero* to ACE inhibitors the following adverse experiences have been reported: Fetal and neonatal death, renal failure, hypoplastic lung development, hypotension, hyperkalemia, skull hypoplasia, limb contractures, craniofacial deformities, intrauterine growth retardation, prematurity and patent ductus arteriosus. (See WARNINGS, Fetal/Neonatal Morbidity and Mortality.)

Clinical Laboratory Test Findings: Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 10 vol%, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0% of patients discontinued therapy due to anemia.

Dther (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

For more detailed information, consult your MSD Representative or see Prescribing Information, Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486 J9V561R2(824)

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AMS Newsmakers

AMI National Park Medical Center recently selected its 1991 Executive Committee. They are **Dr. Brenda Powell**, chief of staff; **Dr. Clinton Schmidt**, vice chief of staff; **Dr. John Simpson**, secretary; **Dr. John Wayne Smith**, chief of medicine; **Dr. John Brunner**, chief of surgery; **Dr. Michael Finan**, chief of obstetrics and gynecology; **Dr. Louis McFarland**, chief of pediatrics; and **Dr. Richard Gardial**, immediate past chief of staff.

Dr. Harold Hedges, of Little Rock, recently was reappointed to the Committee on Scientific Program of the American Academy of Family Physicians.

Dr. Tom Kovalski, a rheumatologist with the Arkansas Arthritis Clinic in Little Rock, has been elected chairman of the board of the Arkansas Chapter of the Arthritis Foundation.

Dr. Lance Lincoln, a general internist with the Burnett-Croom Clinic in Mountain Home, has recently been certified as a Diplomate in Internal Medicine.

Dr. Gary Petrus, chief resident in otolaryngology-head and neck surgery at UAMS in Little Rock, has been selected to present two research papers to The American Society of Pediatric Otolaryngology at their national meeting in May.

The Randolph County Medical Center has announced its officers for 1991. They are **Dr. James F. Murrey**, president/chief of staff; **Dr. James S. Mize**, immediate past chief of staff; **Dr. Albert Baltz**, chief-elect; **Dr. Mark A. Baltz**, secretary/treasurer; and **Dr. Hal Barre**, member at large.

The Springdale Memorial Hospital has announced its new officers for 1991. They are **Dr. C. Muri Baker**, vice chief of staff and **Dr. John B. Weiss**, medical staff secretary.

The Stone County Medical Center has announced its new officers for 1991. They are **Dr. Ron Simpson**, chief of staff; **Dr. N.J. Piediscalzi**, vice chief; **Dr. Carl Beck**, staff secretary; and **Dr. James Zini**, board of directors.

Dr. Kimber Stout, of the Arkansas Cardiology Clinic in Little Rock, has been elected a Fellow of the American College of Cardiology.

Dr. James Weber, of Jacksonville, has been named chairman of the Commission on Health Services of the American Academy of Family Physicians. Dr. Weber is also a member of the Board of Directors of the AAFP.

Physician's Recognition Award

The Physician's Recognition Award is awarded each month to physicians who have completed acceptable programs of continuing education. The recipients for the month of February are:

Thomas H. Allen	Little Rock
Randall E. Cole	Rogers
Joe H. Dorzab	Fort Smith
Thomas L. Eans	Little Rock
Theophilus A. Feild	Fort Smith
Robert L. Fincher	Little Rock
David Fried	Mena
Connie Hiers	Jonesboro
Robert L. Kerr	Mountain Home

Albert S. Koenig	Fort Smith
Hosea W. McAdoo	Little Rock
George O. Paddock	Jacksonville
Norton A. Pope	Little Rock
Norman K. Pullman	Conway
F. Hampton Roy	Little Rock
Rheeta M. Stecker	Hot Springs
Eugene F. Still	Fort Smith
Gerald N. Weiss	Little Rock

AIDS IN ARKANSAS 1991

January 1 - December 31, 1991

Total number of cases reported	29	CASES BY AGE GROUP	
Number of deaths	3	Less than 20	2
		20 - 29	6
		30 - 39	12
		40 - 49	8
		50 or more	1
CASES BY SEX			
Male	27		
Female	2		
CASES BY RACE		OPPORTUNISTIC DISEASE	
White	20	Pneumocystic Carinii	14
Black	9	Cryptococcosis	1
Other	0	Kaposi's Sarcoma	1
		Candida	3
		HIV Wasting Syndrome	3
		Toxoplasmosis	1
		HIV Encephalopathy	1
		Histoplasmosis	3
		Other Diseases	2
CASES BY RISK GROUP			
Homosexual/Bisexual	17		
Homosexual & IV Drug User	4		
IV Drug User	5		
Hemophiliac	1		
Transfusion	0		
Heterosexual (Contacts)	1		
NIR*	1		

* No identified risk group (NIR)

AIDS IN ARKANSAS 1983 - 1991

Total number of cases reported	472	CASES BY AGE GROUP	
Number of deaths	278	Less than 20	16
		20 - 29	143
		30 - 39	206
		40 - 49	75
		50 or more	32
CASES BY SEX			
Male	429		
Female	43		
CASES BY RACE		OPPORTUNISTIC DISEASE	
White	354	Pneumocystic Carinii	218
Black	113	Cryptococcosis	25
Other	5	Kaposi's Sarcoma	14
		Candida	60
		HIV Wasting Syndrome	54
		Toxoplasmosis	9
		HIV Encephalopathy	25
		Histoplasmosis	30
		Other Diseases	37
CASES BY RISK GROUP			
Homosexual/Bisexual	300		
Homosexual & IV Drug User	49		
IV Drug User	49		
Hemophiliac	8		
Transfusion	19		
Heterosexual (Contacts)	24		
NIR*	23		

* No identified risk group (NIR)

Source: Arkansas Department of Health.

New Members

BENTON COUNTY

Baker, James B., Internal Medicine, Bella Vista. Born September 23, 1957, Hot Springs. Medical education, Oklahoma State University College of Osteopathic Medicine, Tulsa, 1987. Internship/residency, Tulsa Regional Medical Center, OK, 1990. Board certified.

Springer, Dan J., Family Practice, Siloam Springs. Born February 18, 1958, Siloam Springs. Medical education, University of Oklahoma, 1984. Internship/residency, University of Oklahoma Tulsa Medical College, 1987. Board certified. Practice experience, 3 years.

CHICOT COUNTY

Jackson, John, General Practice, Eudora. Born July 19, 1962, Michigan. Medical education, Michigan State, E. Lansing, 1982. Internship, St. Barnabus Hospital, Bronx, NY, 1988. Residency, Chicago Osteopathic Hospital, 1990. Board certified.

DREW COUNTY

Williams, William W., DO, Monticello. Born May 23, 1954, Little Rock. Medical education, UHS College of Medicine, Kansas City, MO, 1983. Internship, Riverside Hospital, 1984. Board certified. Practice experience, 2 years.

FAULKNER COUNTY

Martin, David A., Family Practice, Greenbriar. Born May 7, 1956, Conway. Medical education, UAMS, 1983. Residency, AHEC-Pine Bluff, 1986. Board certified. Practice experience, 4 years.

Wilson, Paul H., Ophthalmology, Conway. Born March 24, 1940, Camden. Medical education, UAMS, 1966. Internship/residency, UAMS, 1973. Board certified. Practice experience, 16 years.

GARLAND COUNTY

Bodemann, Diane K., Internal Medicine, Hot Springs. Born March 13, 1958, Colorado. Medical education, University of Kansas Medical School, Kansas City, 1980. Internship/residency, University of Oklahoma, Tulsa, 1988. Board certified. Practice experience, 2 years.

Hansen, Dana P., Radiation Oncology, Hot Springs. Born August 13, 1951, Ft. Madison, IA. Medical education, University of Minnesota Medical School, Minneapolis, 1979. Internship, Tripler Army Medical Center, 1980. Residency, University of Minnesota Hospitals & Clinics, 1986. Board certified. Practice experience, 10 years.

JACKSON COUNTY

Falwell, Kevin W., Family Practice, Newport. Born March 9, 1957, Bradford. Medical education, UAMS, 1987. Internship/residency, AHEC-Pine Bluff, 1990. Board certified.

JEFFERSON COUNTY

Newan, Michael M., Pulmonary, Pine Bluff. Born August 20, 1959, Vietnam. Medical education, University of Illinois School of Medicine, Rockford, 1984. Internship, University of Illinois Hospitals & Clinics, 1988. Residency, Loyola University/Hines VA, 1990. Board certified.

MISSISSIPPI COUNTY

Lin, Ching-Shan, Internal Medicine, Osceola. Born December 1, 1946, Taiwan. Medical education, University of Juarez, Mexico, 1982. Internship, Fairview General Hospital, Cleveland, OH, 1984. Residency, McLaren General Hospital, Michigan State University, Flint, 1990. Board certified.

OUACHITA COUNTY

Armato, Andrew A., Radiology, Camden. Born November 11, 1926, Winchester, MA. Medical education, Kirksville College of Medicine, MO, 1958. Internship, Lakeview Hospital, Milwaukee, WI, 1959. Residency, Saginaw Osteopathic Hospital, 1964. Board certified. Practice experience, 31 years.

PHILLIPS COUNTY

Epstein, S. Mitchell, Radiology, Helena. Born April 3, 1952, Memphis, TN. Medical education, University of Tennessee, Memphis. Internship, Methodist Hospital, Memphis. Residency, Baptist Hospital, Memphis, 1982. Board certified. Practice experience, 9 years.

POLK COUNTY

Lochala, Richard M., Family Practice, Mena. Born November 21, 1953, Crossett. Medical education, UAMS, 1987. Internship/residency, Anderson Memorial Hospital, 1990. Board certified.

PULASKI COUNTY

Bates, Ramona L., Plastic Surgery, Little Rock. Born July 29, 1957, Ft. Leonard Wood, MO. Medical education, UAMS, 1982. Internship/residency, Earl K. Long Hospital, Baton Rouge, LA; Ohio Valley Medical Center, Wheeling



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WV; Mercy Hospital, Pittsburgh, PA; Boston University Hospital, Boston MA, 1989. Practice experience, 5 years.

Bayliss, John M., Nephrology, Little Rock. Born April 30, 1953, Siloam Springs. Medical education, Tulane School of Medicine, New Orleans, LA, 1980. Internship/residency, UAMS, 1983. Practice experience, 8 years. Board certified.

Bell, Rex H., Pathology, Little Rock. Born September 28, 1954, Camden. Medical education, UAMS, 1985. Internship/residency, UAMS, 1990. Board certified.

Bower, Charles M., Otolaryngology, Little Rock. Born November 3, 1958, Durham, NC. Medical education, UAMS, 1985. Internship/residency, UAMS, 1990. Board certified.

Brown, Steven L., Adolescent & Child Psychiatry, Little Rock. Born June 11, 1951, Superior, NE. Medical education, UAMS, 1982. Internship/residency, University of Texas Health Science Center, San Antonio, 1986. Practice experience, 4 years.

Carttar, Charles D., General Practice, Little Rock. Born June 27, 1953, Little Rock. Medical education, UAMS, 1980. Internship/residency, St. Vincent's Infirmary, Little Rock, 1981. Practice experience, 9 years.

Clark, John R., Orthopaedic Surgery, Little Rock. Born November 18, 1952, Heber Springs. Medical education, UAMS, 1980. Internship, University Hospital,

Little Rock, 1980. Residency, University of Tennessee College of Medicine, Chattanooga, 1986. Practice experience, 5 years. Board certified.

Hnilica, Violette S., Pathology, Little Rock. Born September 25, 1939, Archbold, OH. Medical education, Baylor University College of Medicine, Houston, 1965. Internship/residency, Baylor Affiliated Residencies, Houston. Board certified.

Johnson, Anthony D., Pediatrics, Little Rock. Born August 20, 1954, Wichita, KS. Medical education, UAMS, 1980. Internship, University Hospital, Little Rock, 1981. Residency, Arkansas Childrens' Hospital, Little Rock, 1983. Board eligible.

Kramm, Paul C., Physical Medicine & Rehabilitation, Sherwood. Born June 26, 1957, St. Paul, MN. Medical education, University of Minnesota Medical School, Minneapolis, 1986. Internship/residency, McKennan Hospital, Sioux Falls, SD, 1987; University of Minnesota, Minneapolis, 1990. Board eligible.

Owings, Debra V., Pathology, Little Rock. Born September 15, 1953, Little Rock. Medical education, UAMS, 1985. Internship/residency, Beth Israel Hospital, Boston, MA, 1990. Board certified.

Owings, Richard, Psychiatry, Maumelle. Born August 23, 1949, Denver, CO. Medical education, UAMS, 1984. Internship, UAMS, 1985. Residency, Massachusetts

Mental Health Center, Harvard Medical School, Boston. Practice experience, 2 years. Board certified.

Pahls, Woodell L., Emergency Medicine, Little Rock. Born October 15, 1957, San Diego, CA. Medical education, UAMS, 1983. Internship/residency, UAMS, 1986. Practice experience, 7 years. Board certified.

Rouse Jr., Lucien M., Orthopaedic Surgeon, Little Rock. Born October 4, 1956, Lexington, KY. Medical education, University of Texas Southwestern Medical School, Dallas, 1984. Internship, University of Texas Health Science Center, Dallas, 1985. Residency, University of Texas Health Science Center, Dallas, 1989. Practice experience, 1 year. Board eligible.

Sanderson, M. Bruce, Internal Medicine, Little Rock. Born October 13, 1946, Stuttgart. Medical education, UAMS, 1972. Internship/residency, Keesler Medical Center, Biloxi, MS, 1976. Practice experience, 15 years.

Tressler, Samuel D., Pediatrics, North Little Rock. Born February 1, 1951, Dallas, TX. Medical education, University of Texas Southwestern Medical, Dallas, 1977. Internship, UAMS, 1978. Residency, Arkansas Childrens' Hospital, 1980. Practice experience, 10 years. Board certified.

Vinsant, Kurtis S., General & Vascular Surgery, Little Rock. Born December 3, 1956, Little Rock. Medical

education, UAMS, 1985. Internship/residency, UAMS, 1990. Board eligible.

Winburn, Mary B., Neurology, Little Rock. Born July 25, 1930, Little Rock. Medical education, UAMS, 1954. Internship, Orange Memorial Hospital, Orlando, FL, 1955. Residency, UAMS, 1967; George Washington University Hospital, Washington, DC, 1971; UAMS, 1988. Practice experience, 26 years. Board certified.

SALINE COUNTY

Dockery, Melissa H., Family Practice, Benton. Born July 19, 1955, Ruleville, MS. Medical education, University of Mississippi School of Medicine, Jackson, 1982. Internship/residency, University of Tennessee, Knoxville, 1985. Board certified. Practice experience, 6 years.

SEBASTIAN COUNTY

Bell, Timothy J., OB/GYN, Fort Smith. Born June 20, 1956, Helena. Medical education, University of Health Sciences, Kansas City, MO, 1985. Internship, Lakeside Hospital, Kansas City, MO, 1986. Residency, Metropolitan Medical Center, St. Louis, MO, 1991. Board eligible.

Bouton, Michael S., General Surgery, Fort Smith. Born August 8, 1956, Brooklyn, NY. Medical education,



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Texas Tech School of Medicine, Lubbock, 1984. Internship/residency, University of Texas Medical Branch, 1990. Board eligible.

Burt, William J., Family Practice, Fort Smith. Born November 1, 1960, Ozark. Medical education, UAMS, 1987. Internship/residency, AHEC-Fort Smith.

WASHINGTON COUNTY

Garner, Hershel H., Radiation Oncology, Springdale. Born July 19, 1953, Little Rock. Medical education, UAMS, 1986. Internship, UAMS, 1987. Residency, University of Louisville, KY, 1990. Board certified.

WHITE COUNTY

Ferrell Jr., Griffith H., Emergency Medicine. Born September 18, 1929, Little Rock. Medical education, UAMS, 1965. Internship, John Peter Smith Hospital, Fort Worth, TX, 1966. Practice experience, 24 years. Board certified.

Holston, John S., Internal Medicine, Searcy. Born, July 13, 1950, Stuttgart. Medical education, UAMS, 1976. Internship/residency, UAMS, 1979. Practice experience, 6 years. Board certified.

RESIDENT

Breau, Randall L. Born January 28, 1964, Baton Rouge, LA. Medical education, LSU, Shreveport, 1990. Internship, UAMS.

In Memoriam

J.B. Futrell, M.D.

J.B. Futrell, M.D., of Rector, died Thursday, February 14, 1991. He was 87.

Dr. Futrell was a retired general practitioner, a veteran of World War II, and a member of the Arkansas Medical Society.

Dr. Futrell is survived by a son, Marion Futrell of Mount Zion, IL; a daughter, Carolyn Cook of Rector; a brother, Dan Futrell of Hot Springs; two sisters, Janice Moore of Batesville and Nye McCall of Merced, CA; and six grandchildren and three great-grandchildren.

George Graham, M.D.

George Graham, M.D., medical director at the surgical intensive care unit and chairman of the critical care committee of professional staff at Baptist Medical Center in Little Rock, died Thursday, March 7, 1991. He was 69.

Dr. Graham served in the Navy, was an Army veteran of World War II, and volunteered as a chest surgeon at a hospital in South Korea. Dr. Graham was a member of the Pulaski County Medical Society, Arkansas Medical Society, American Medical Association, a Fellow with the American College of Surgeons and American College of Chest Physicians, a member of the Southwestern Surgical Society, Pan Pacific Surgical Society, Pan American

Surgical Society, past president of the Arkansas section of the American Thoracic Society and past president of the Little Rock Academy of Surgeons.

Dr. Graham was a professor of clinical surgery at UAMS, past chief of staff at Arkansas Children's Hospital and Baptist Medical Center and past chief of surgery at Baptist Medical Center and Baptist Memorial Medical Center.

Survivors are his wife, Barbara Holt Graham; three sons, G. Grimsley Graham Jr. of Rogers and Larry L. and Louis A. Graham of Little Rock; a sister, Jacqueline Alexander of Brinkley; and four grandchildren.

Keith E. Ashcraft, M.D.

Keith E. Ashcraft, M.D., an anesthesiologist and former chief and vice chief of anesthesiology at Doctors Hospital in Little Rock, died Tuesday, March 5, 1991. He was 42.

Dr. Ashcraft was affiliated with the Capitol Anesthesia Group, a member of the American Society of Anesthesiology, American Medical Association, Arkansas Medical Society, International Anesthesia Research Society, and Credentials Committee at Doctors Hospital.

Survivors are his wife, Sue Barnett Ashcraft; two daughters, Leah and Sarah Ashcraft of Little Rock; his parents, Ev and Hazel Ashcraft of Pine Bluff; and a brother, David Ashcraft of Beaumont, TX.

MODULATE/DEMODULATE

MODEM

EGA CLEARING HOUSE

PC-XT/AT XENIX

CGA ELECTRONIC CLAIMS SUBMISSION

MEGAHERTZ RAM

REMOTE ACCESS VGA

ASYNCHRONOUS MEGABYTES ROM ARCNET

SERIAL PORTS MIPS

HIGH DENSITY

TACTILE HARD DISK

WORKSTATIONS VGA

9 PIN DOT MATRIX DATA TRANSFER

UNATTENDED POLING CPS

BARCODE RE

DOS PARALLEL INTERFACE

MAGNETIC MEDIA MGA

MONOGRAPHIC ADAPTER

LOCAL PRINTER

AT COMPATIBLE BAUD RATE

WORM DRIVE A-B SWITCH

WEDGE DATA TERMINALS

MULTI-USER ENVIROMNEN

NETWORKING

ACCEPT ASSIGNMEN

CROSSOVER CLAIM EDS

CHARGE SLIPS HMO WRITE-OFF

CURRENT PROCEDURAL TERMINOLOGY

OUTSIDE LAB CHARGES

SUPERBILL PPO

WORKMAN'S COMP

ICD DIAGNOSIS CODES

REFERRING PHYSICIAN SECONDARY

GROUP NUMBER HICFA

PLACE OF SERVICE CODE

PRIMARY CARRIER

PRIOR AUTHORIZATION

TYPE OF SERVICE CODES

SAME/SIMILIAR INDICATOR

PATIENT CHARTS DAY SHEETS

SUPERBILL

CPT PROCEDURE CODES

WAITING LEDGER CARDS WRITE-OFF PARTICIPATING PHYSICIAN

ROOM INSURANCE CARDS GROUP PLOICY NUMBER CHARGE SLIPS MEDICARE

DISABILITY PATIENT STATEMENTS RELATIONSHIP TO THE INSURED PAYMENT

APPROVED AMOUNT TYPEWRITER

APPOINTMENT BOOK EXAMINATION ROOM TICKLER FILES CODING REQUIREMENTS

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DATE OF ACCIDENT PATIENT RECORDS RESPONSIBLE PARTY

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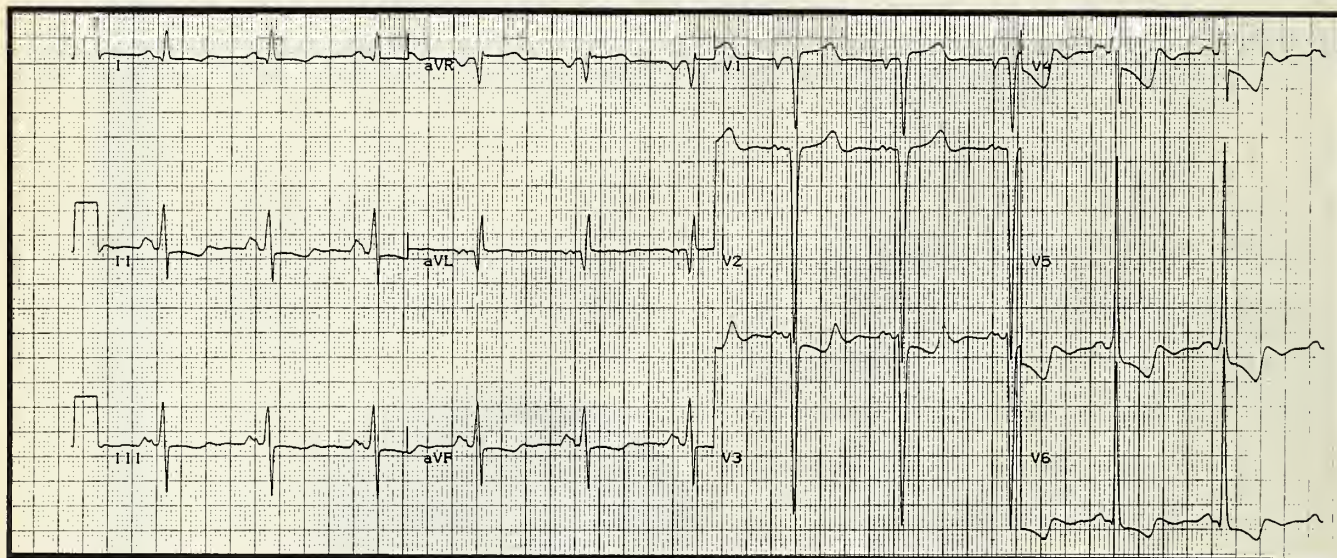


Electrocardiogram of the Month

Jon P. Lindemann, M.D.
UAMS Division of Cardiology
Little Rock, Arkansas

CLINICAL HISTORY:

This record was obtained from a 44 year-old male.



DISCUSSION:

This is an abnormal ECG. Normal sinus rhythm is present. The P waves are broad (>0.12 sec) in the standard limb leads and have a broad, negative component in lead V_1 . Although this pattern is frequently termed left atrial hypertrophy or enlargement, the more correct term is **left atrial abnormality**, as the surface ECG cannot reliably distinguish between left atrial hypertrophy or enlargement or an inter-atrial conduction abnormality. Examination of the precordial leads reveals a QS pattern in V_1 and V_2 with "poor R wave progression." Voltage criteria for left ventricular hypertrophy are also present. Non-specific ST-T wave abnormalities are present in V_3 - V_5 as well as in the regular and augmented limb leads. The combination of voltage criteria, non-specific ST-T abnormalities and left atrial abnormality result in an electrocardiographic diagnosis of **left ventricular hypertrophy (LVH)**.

The presence of the QS pattern would lead many (including the computer) to read an anteroseptal infarction. However, this QS pattern may be seen in the absence of an anteroseptal infarct, and be due to LVH. Although serial records may be required to exclude a diagnosis of infarction, the possibility this pattern representing non-infarction Q waves may be evaluated by repeating the ECG with the precordial leads placed in interspace lower. In the absence of infarction, such an ECG would reveal initial R waves in the right precordial leads.

Medicine in the News

Health Care Access Foundation Update

As of February 1991, the Arkansas Health Care Access Foundation has provided free medical services to 2,554 medically indigent persons.

The program has 1,420 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.

Evaluating the Purchase of New Medical Technology

In this period of burgeoning medical technology, reduced reimbursements, and increased competition, physicians are often torn between the imperatives of fiscal restraint and expanded services. Amazing new technological developments hold exciting promise for patient treatment - and demand significant financial investments from a medical practice. The challenge for most practices is determining the long-term benefit of investing in a piece of new technology - and balancing that with the immediate financial and marketing risks.

According to The Health Care Group, the decision-making process can be quite complex, because there are so many clinical, financial, and marketing factors to weigh. The key is to quantify both the benefits reasonably expected from the new technology - in terms of clinical effectiveness, patient convenience, and practice revenues - and the costs and risks implied - in terms of operations, marketing, and liability.

The Health Care Group recommends the following specific questions that practices can use to guide their technology-acquisition decisions:

- Will the new equipment enable you to better deliver care to your patients? Provide additional convenience to your patients? Provide better response time with test results?
- Will the new equipment enable you to practice more efficiently and productively? Can diagnostic tests and office procedures be performed more efficiently?
- Can this service be provided with current equipment? Or, can present equipment be modified rather than replaced?
- Can patients pay for the new service procedure? Do third-party payors recognize the benefit of the new

technology? Is the equipment FDA approved? Will lack of FDA approval

- What additional training is required for physicians and staff? What is your liability exposure relative to your degree of training with this equipment?
- Given the regulatory and reimbursement climate developing, will enough dollars be generated to justify the cost, training, space, staffing, and time investments?
- How likely is it that this technology will be replaced with better and/or more sophisticated equipment or procedures in the foreseeable future? In what other environments is this equipment used?
- Will the new equipment create a competitive advantage?
- Could this business step impair your relations with current referrers or hospitals? How can this potential damage be minimized?

In tough economic times, doctors should carefully weigh the benefits and risks of investing in new equipment and services.

Physicians' Schedules Must Meet Needs of Busy Patient Population

Too many physicians view office scheduling as nothing more than a method of ordering their own time. Yet, a well conceived appointment schedule can provide broad benefits for the practice, including improved efficiency and reduced stress for physicians and staff. Foremost, an effectively structured scheduling system will smooth patient flow through a practice while increasing patients' satisfaction with the attention and care they receive.

According to The Health Care Group, in coming years there will be a call for greater scheduling flexibility to meet the needs of a working patient population. In choosing a physician, patients will increasingly ask, "How flexible are the office hours, and is there a reasonable choice of appointment times?" And to assure their practices' viability, doctors must ask themselves, "If our scheduling system were more effective, could new services be offered to lure new patients; or could we provide greater convenience to current patients?"

Demonstrating respect for a patient's own time and schedule is essential. Therefore, for most practices, decreasing the amount of time patients wait to receive an appointment and the time spent in the reception area is a priority. The amount of time spent waiting is closely related to a patient's assessment of the value of a visit. Recent studies show that an average patient will not accept a wait longer than 30 minutes before becoming angry. In addition, patients are increasingly frustrated when physician's schedule does not permit sufficient time for discussion about the illness and treatment plan, and for patients' questions.

To gauge patients' response to a practice's current scheduling system, a survey by mail or during office visits is recommended. Such a survey can also be used to ask about satisfaction with other areas of the practice. But ask questions only when willing to respond to the patients' needs - a lack of responsiveness will only anger patients.

With the survey results in hand, a practice can consider necessary changes in its current schedule format. The revision should result in a customized format, unique to the practice's needs and goals, which can be printed as customized pages or entered on a computerized screen.

When a new appointment schedule is ready for operation, guidelines for its use should be developed, given to all doctors and staff, and included in the practice's policy manual.

Below are several tips on effectively implementing the new schedule:

- Designate scheduling responsibility to a single staff member.
- Physicians must set a good example; their adherence to the guidelines reinforces staff adherence. Doctors should keep a copy of each day's appointment schedule to follow as patients are seen.
- Develop an appointment triage - a set of questions to be asked to determine patients' reasons for calling. The responses will help allot each patient the appropriate amount of time.
- Start on time. Starting the day even 15 minutes late is a guarantee of ending the day feeling rushed.
- See patients in the appropriate sequence. Patients who are early should not necessarily be seen before a person who comes on time, unless this can be done without making the on-time patient wait. Never allow a scheduled patient to wait while walk-ins are seen, except in an emergency.
- Designate appointment slots for emergencies and referred appointments; availability may be a physician's greatest asset.
- Maintain a "tickler" file of patients who can be contacted quickly to replace cancellations.
- Make reminder calls to those patients with lengthy appointments or those who frequently forget their appointments.

Practices should review scheduling system to assure smooth and efficient service to patients.

Clinic For Sale

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Robert E. Baumann, Administrator
Booneville City Hospital
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Radiological Case of the Month

C.J. Fuller, M.D.
F. Anthony Bennett, M.D.
Steven R. Nokes, M.D.
David L. Harshfield, M.D.

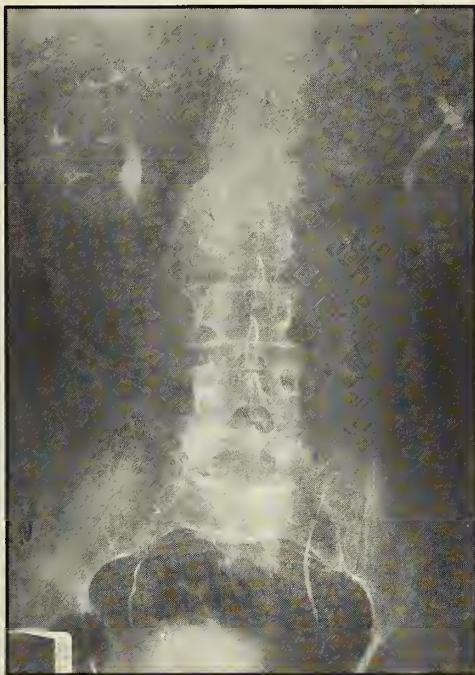
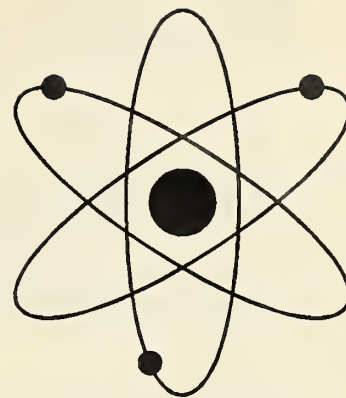


Figure 1. Ten minute IVP film.

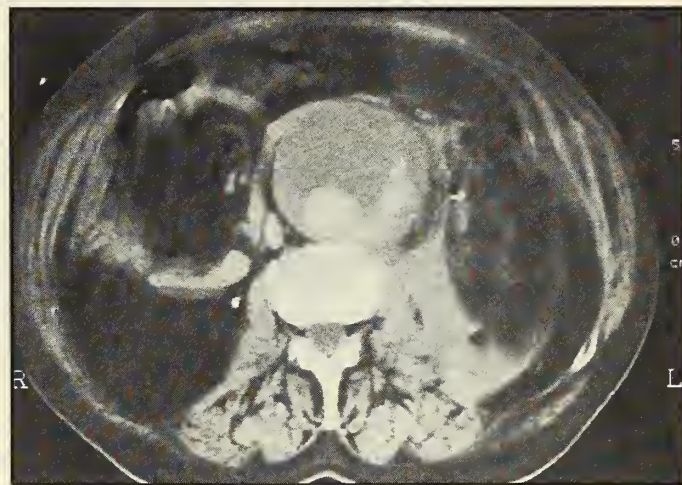


Figure 2. CT scan of the mid abdomen.

Clinical History:

This 81 year-old male presented with sudden onset of left flank and back pain with hematuria. His blood pressure was 142/80 and pulse was 90. An IVP and CT scan were performed.

Ruptured Abdominal Aortic Aneurysm

Radiographic Findings:

The IVP reveals displacement of the left kidney and ureter laterally, without evidence of obstruction. The left psoas margin is obscured and a round soft tissue density projects to the left of the L₁₋₃ vertebral bodies. The CT scan demonstrates a 9cm abdominal aortic aneurysm with recent hemorrhage in the left psoas muscle and retroperitoneum.

Discussion:

Mortality for all patients with ruptured abdominal aortic aneurysms exceeds 75%. Only 40% of patients who are admitted to the hospital survive for 24 hours. The typical presentation is severe abdominal and back pain with pulsatile mass. Patients who are hemodynamically unstable with suspected aneurysm rupture should undergo immediate surgery, while those with stable vital signs can be examined by CT.

CT easily identifies abdominal aortic aneurysms as focal areas of aortic dilatation. Acute extraluminal blood has a serpiginous, finger-like appearance as it infiltrates into the fascial planes of the retroperitoneum. Intravenous contrast frequently demonstrates the site of disruption of the aortic wall, which is helpful to the surgeon in establishing hemostasis.

Occasionally, a patient's CT examination will not demonstrate a leak which is subsequently proven at surgery. If the rupture is small and contained, extraluminal blood can be difficult to detect. Impending rupture cannot be predicted by CT, and patients with large (5cm or greater) symptomatic aneurysms should be monitored closely. Semi-elective surgery, within 24 to 48 hours, may be preferable in these cases as mortality falls to 17%. Emergency surgery mortality rates are between 35% and 50%. Mortality for purely elective repairs varies from 2% to 8%. Many studies are truly negative for aneurysm rupture, and CT identifies nonvascular causes of pain in up to 40% of cases.

Our patient recovered following prompt aneurysm repair.

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1. Gale ME, Johnson WC, Gerzof SG, Robbins AH. Problems in CT diagnosis of ruptured abdominal aortic aneurysms. *J Comput Assist Tomogr* 1986; 10:537-541.
2. Greatorex RA, Dixon AK, Flower CDR, Pulvertaft RW. Limitations of computed tomography in leaking abdominal aortic aneurysms. *Brit Med J* 1988; 297:284-285.
3. Zarnke MD, Gould HR, Goldman MH. Computed tomography in the evaluation of the patient with symptomatic abdominal aortic aneurysm. *Surgery* 1988; 103:638-642.

Contributor: C.J. Fuller, M.D., is in private practice and is affiliated with Radiology Consultants in Little Rock.

Contributor: F. Anthony Bennett, M.D., is in private practice and is affiliated with Cardiology Consultants in Little Rock.

Editor: Steven R. Nokes, M.D., is in private practice and is affiliated with Radiology Consultants in Little Rock.

Editor: David Harshfield, M.D., chief of the radiology service at the Veterans Administration Hospital in Little Rock, and head of radiology at Riverside Radiologist Group in North Little Rock.

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Things To Come

April 21-23

8th National Conference on Prescription Medicine Information & Education. Omni Shoreham Hotel, Washington, DC. Sponsored by the National Council on Patient Information and Education. For more information, call (202) 347-6711.

April 25-26

8th Annual Symposium on Obstetrics & Gynecology. Wohl Auditorium, Washington University Medical Center, St. Louis, MO. Sponsored by the Washington University School of Medicine and presented by the Department of OB/GYN and the Office of CME. CME Category I credits available. Fees: \$250, physicians; \$125, physician in training and allied health professionals. For more information, call Cathy Caruso at 1-800-325-9862.

April 26-28

Diagnostic Dilemmas in Cardiology. Kingston Plantation, Myrtle Beach, SC. Sponsored by the SMA. CME Category I credits available. For more information, call LaDonna Nail at 1-800-423-4992.

April 30-May 2

Molecular Basis of Bone Cell Physiology: Transcellular Signaling. The Sheraton West Port Inn, St. Louis, MO. Sponsored by the Washington University School of Medicine. For more information, call Cathy Caruso at 1-800-325-9862.

May 1-3

Protection for Research Risk. The Hyatt Regency, Union Station, St. Louis, MO. Sponsored by the Washington University School of Medicine. For more information, call Cathy Caruso at 1-800-325-9862.

May 3-5

Diagnostic Dilemmas in Neurology and Psychiatry. The Grand Hotel, Point Clear, AL. Sponsored by the SMA. CME Category I credits available. For more information, call LaDonna Nail at 1-800-423-4992.

May 17-18

Low Back & Sciatic Pain: Evaluation and Treatment. Washington University Medical Center, St. Louis, MO. Sponsored by Washington University Medical Center. For more information, call Cathy Caruso at 1-800-325-9862.

May 20-22

Advanced Laparoscopic Surgery. Westin Hotel, Indianapolis, IN. Sponsored by St. Vincent Hospital and Health Care Center, Indianapolis. Fees: \$450.00, physicians; \$350, residents. For more information, call Beth Hartauer at (317) 871-3460.

June 1

Immunologic Aspects of Liver Transplantation. Rush-Presbyterian-St. Luke's Medical Center Inn at University Village, Chicago, IL. Sponsored by the Section of Transplantation Department of General Surgery, Rush-Presbyterian-St. Luke's Medical Center. CME credit applied for. For more information, call 1-800-942-6242.

June 9-13

15th Lung Symposium. The Cloister, Sea Island, GA. Sponsored by the Southern Medical Association. For more information, contact LaDonna Nail at 1-800-423-4992.

June 17-19

Breast Cancer Diagnosis: Interventional Procedures. The Westin Resort, Hilton Head, SC. Sponsored by Siemens Medical Systems, Inc. For more information, call Ted Pensiero (908) 906-3807 or Jenny Adamiec (908) 906-3800.

June 28-30

Frontiers in Endosurgery. Washington University Medical Center, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862.

July 20-27

9th Annual Medical Seminar. Plummer's Great Slave Lake Lodge, Northwest Territories, Canada. Sponsored by North Memorial Medical Center and the University of Minnesota Department of Family Practice and St. John's Regional Health Center. CME Category I available. For more information, call (612) 588-9478.

August 1-3

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8th Annual W.W. Stead Arkansas Chest Symposium

May 4-5, times to be announced. Co-sponsored by the UAMS College of Medicine and the Arkansas Thoracic Society. University Conference Center, # 1 Statehouse Plaza, Little Rock. For more information, call 686-5525.

2nd Annual Ozark Regional Symposium

May 3-4, times to be announced. Sponsored by St. Mary's-Rogers Memorial Hospital. Springdale Holiday Inn Atrium Hotel and Convention Center. Fees: \$125.00, medical/administrative personnel or \$100.00 for a group of five or more; \$75.00 for allied health professionals or \$60.00 for a group of five or more. For more information, call (501) 636-0200, ext. 673.

13th Annual Family Practice Intensive Review

June 7-9, times to be announced. Sponsored by UAMS College of Medicine and presented by Ben Saltzman, M.D. UAMS Education II Bldg. Fee: \$200.00. Credits to be announced.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

CME Luncheon, second & fourth Friday, 12:30 p.m. AMI Ozark-Quapaw Room. One Category I credit per meeting.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), third Wednesday, 12:30 p.m., conference room, Bldg. 1, VAMC
Medical Grand Rounds, Fridays, 12:00 noon, VAMC

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Faculty Resident Seminar, third Thursday, 12:00 noon, Sturgis Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457
Infectious Disease Conference, second Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium
Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., 2nd Floor Classroom
Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, 2nd Classroom
Pediatric Research Conference, first Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

Sleep Disorders Case Conference, first & third Thursday, video production conference room. Lunch provided
Interdisciplinary AIDS Conference, second Friday, 12:00 noon. LaHarpe Room. Sandwich buffet is served
Cancer Conference, third Thursday, 12:00 noon, Laboratory conference room. Lunch is provided
Hematology-Oncology Conference, second Thursday, 12:00 noon. Lunch is provided
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments are provided
Pulmonary Conference, second & fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet is served
Journal Club, every Tuesday, 12:00 noon, Lunch is provided
GYN Surgery Cancer Conference, second Monday, 12:00 noon. Lunch is provided
Joint Tumor Conference, first Wednesday, 12:00 noon. CARTI Auditorium. Lunch is provided

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., conference room 1
GI Conference, fourth Friday, 12:00 noon. Lunch is provided
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lectures & case presentations. A light lunch is provided
Pathology Conference, first Tuesday, 3:00 p.m., Pathology Library

Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor/BMC. Lunch is provided
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch is provided
Sleep Case Conference, Fridays, 12:00 noon. Lunch is provided

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC Oncology Forum, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits
Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Anesthesia Morbidity & Mortality Conference, Tuesdays, 6:45 a.m.; second & fourth Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Arkansas Blood & Cancer Society Conference, sixth Thursday, 7:30 p.m. Terrace Restaurant, Little Rock
CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy
Cardiothoracic Surgery Conference, date, time, & location varies
Cardiothoracic Surgery Monthly Journals Club, fourth Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Cardiothoracic Surgery Morbidity & Mortality Conference, second Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B
Emergency Medicine Grand Rounds 1, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B
Emergency Medicine Grand Rounds 2, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B
Gastroenterology Grand Rounds, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293
Hematology/Oncology Fellow's Forum, Fridays, 8:15 a.m., ACRC Betsy Blass conference room
Little Rock Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC conference room thrice, CARTI Auditorium once a month
Little Rock Vascular Conference, time & date varies monthly, rotates between UAMS, SVI & BMC
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B
Med/Path Conference, third or fourth Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306
Medicine Research Conference, three Wednesdays a month, 4:30 p.m. UAMS Education Bldg. room B/135
Neurology Clinical Case Conference, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH
Neuropathology Conference, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Ob/Gyn Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours
Orthopaedic Basic Science Conference, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135
Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
Surgery Basic Sciences Conference, first Saturday, 7:30 a.m., ACRC 2nd floor conference room
Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room
Surgery Morbidity & Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room
Surgery Resident Case Conference, second, third, fourth, fifth Saturday, 7:30 a.m., ACRC 2nd floor conference room
Trauma Morbidity & Mortality Conference, date & time varies monthly, ACRC 2nd floor conference room
VA Chest Conference (combined Surgical/Medical Chest Conference), Mondays, 12:15 p.m., VAMC-LR, room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173
VA GRECC/Geriatric Research Conference, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109
VA Hematology/Oncology Conference, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142
VA Lung Cancer Conference, Thursdays, 3:00 p.m., VAMC-LR, room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130
VA Medicine-Pathology Conference, Tuesday, 2:00 p.m., VAMC-LR, room 2D109
VA Medicine Resident's Clinical Case Conference, Fridays, 12:00 noon, VAMC-LR, room 2D08
VA Physical Medicine & Rehab Grand Rounds, fourth Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine Conference, second, third, & fourth Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118
VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology conference room

EL DORADO - AHEC

Behavioral Sciences Conference, first & fourth Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital

Gynecology-Pathology Conference, second Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second & fourth Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, fourth Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, first, second & third Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

Behavioral Sciences Conference, third Wednesday, 12:00 noon, Washington Regional Medical Center
City Hospital Staff Medical Meeting, second Friday, 12:00 noon, Fayetteville City Hospital
Family Medicine Conference, first, third, fourth Thursday; fourth Wednesday; second Thursday (odd months) AHEC-NW
Interesting Case Conference, 1st & 3rd Friday, 12:00 noon, Fayetteville City Hospital
Medicine Conference, first & third Tuesday, 12:00 noon, Washington Regional Medical Center
Pediatric Conference, second Wednesday, 12:00 noon, Washington Regional Medical Center
Surgery Conference, second Tuesday, 12:00 noon, Washington Regional Medical Center Fulbright Board room

FORT SMITH - AHEC

Internal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center
Neuroradiology Conference, third Wednesday, 12:00 noon, St. Edward Mercy Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first & third Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.
Chest Conference, second Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided
Craighead/Poinsett Medical Society, first Tuesday, 7:00 p.m. Jonesboro Country Club
Eaker AFB CME Conference, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria
Independence County Medical Society, second Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, fourth & fifth Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.
Jackson County Medical Society, third Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, third Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, second Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neuroradiology Conference, third Friday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided.
Pocahontas CME Conference, third Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom
Tumor Conference, 2nd Thursday, 4th Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided
Walnut Ridge CME Conference, third & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

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Behavioral Science Conference, first & third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second & fourth Friday, 12:00 noon, Jefferson Regional Medical Center
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Internal Medicine Conference, second & fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center
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Orthopedic Case Conference, second & fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates from St. Michael Hospital to Wadley Regional Medical Center
Neuro-Radiology Conference, first & third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st through 4th Friday, 12:00 noon, alternates from Wadley Regional Medical Center & St. Michael Hospital

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Corporal Punishment In Our Schools

H. Patrick Stern, M.D., F.A.A.P.*

Public schools in Arkansas have for years had the highest rate of corporal punishment in schools (13%) of any state in our country. Since the only countries in the industrialized world which permit corporal punishment are schools in South Africa, part of Australia and part of Canada, school children in Arkansas may be subject to the highest rate of corporal punishment in schools anywhere in the world. Should Arkansas be proud of this position, or hang our heads in shame?

A great deal of research has been conducted on corporal punishment and its use in schools. Studies have shown that its use is sexually, racially and socioeconomically biased. Males, blacks, and poor students are far more likely to be hit. Vandalism and violent student behavior is higher when corporal punishment is used. States with the highest rates of corporal punishment in schools have been found to have increased drop out rates from schools and prison admissions. Academic achievement in schools and self esteem have been found to be adversely affected by the use of corporal punishment. Recent research has also found that children who are hit in school are at risk for developing Post Traumatic Stress Disorder.

Research has also shown that the use of alternative methods of behavioral management in schools is more effective to instill self control in students than using corporal punishment. Studies have also found that districts which eliminate corporal punishment do **not** have an increase in behavioral problems when corporal punishment is stopped. The Little Rock School District, which banned corporal punishment a couple of years ago, exemplifies this. It is true that a district which has corporal punishment must implement alternative forms of discipline, but no district or state which banned corporal punishment in schools has experienced that their students suddenly get out of control.

Most professionals who specialize in behavior of chil-

dren expected the United States Supreme Court to eliminate corporal punishment in American schools by extending constitutional protection from physical violence to children. When this did not happen, it created an interesting paradox for students. Criminals are protected from physical violence. Children who become criminals are given constitutional protection from physical violence being done to them. Though children who are criminals are not allowed to be hit in school, children who do not have serious violations of the law can be hit.

Twenty-one states in our country have banned corporal punishment in schools, as have many districts including most large cities such as Atlanta, Los Angeles, Chicago, and New York. In our own state, the Little Rock and North Little Rock School Districts have banned corporal punishment. Based on these state laws and district policies, over half the children in the United States can no longer be hit in school today. It is noteworthy that five countries have banned corporal punishment not only in schools but also in the home. These countries include Denmark, Sweden, Norway, Finland, and Austria.

Clearly the people of Arkansas must hang their heads in shame that our children suffer the highest rate of corporal punishment in schools in our country. Every Arkansas physician should attempt to get this archaic and barbaric practice stopped by lobbying their schools, school boards, Department of Education and their state government, especially Governor Clinton who identifies himself as an education proponent. I would urge that the Arkansas Medical Society adopt the policy statement of the American Academy of Pediatrics which seeks (1) the legal prohibition by all states of corporal punishment in schools and (2) the employment of alternative methods of managing student behavior.

According to Maslow's Hierarchy, physical safety is second only to physiological integrity (such as breathing) to ensure that people can be emotionally healthy. Students must be emotionally healthy in order to fulfill their learning potential. Corporal punishment must be banned in school to keep our children safe. After all, children are people too.

* Dr. Stern is chief, section of Behavioral Pediatrics, and associate professor, Pediatrics, Psychiatry and Behavioral Science at Arkansas Children's Hospital in Little Rock, Arkansas.

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Selective Posterior Rhizotomy For Relief of Spasticity

Frederick A. Boop, M.D.*

William M. Chaddock, M.D.**

Results of sensory rhizotomy for the treatment of spasticity have been dramatically improved by newer microsurgical techniques employing intraoperative electrophysiological monitoring. This is now the treatment of choice for spasticity related to cerebral palsy. The goal of surgery is to achieve a permanent reduction in spasticity thereby improving ambulation and activities of daily living.

The procedure utilizes microsurgical dissection of nerve rootlets for L2 to S2. Individual sensory rootlets are isolated and stimulated in conjunction with electrophysiologic recording of the response of the muscles in the lower extremities. Those rootlets which generate a purely "spastic" response are sectioned. Those giving a more normal response are spared. Care is taken to spare the ventral or motor root. Refinements in technique account for improved results, but emphasis on proper patient selection remains of utmost importance for the success of the procedure.

Introduction

In the late 19th century Sherrington noted that cats made spastic by mid-brain lesions could have relief of spasticity by cutting the sensory roots or deafferenting the involved limb. Total sensory rhizotomy however, was found to be disabling, interfering not only with pain and temperature sensation but with the tactile sensation and proprioceptive input necessary for effective limb movement. In recent years, advances in microsurgical technique as well as intraoperative computer-assisted neurophysiologic monitoring have allowed refinements in the surgical treatment of spasticity. Following the work of Fasano¹, Peacock², has extended the use of selective posterior rhizotomy to treat the spasticity of children with cerebral palsy with excellent and long-lasting results. A number of centers in the United States^{3,4} have gained experience with the treatment of children with static encephalopathies in whom spasticity is a disabling side-effect. At the Arkansas Children's Hospital we have appreciated comparable results following initiation of our rhizotomy program.

Patient Selection

Not all individuals with spasticity are candidates for selective rhizotomy. The ideal patient might have had a cerebral hemorrhage at birth with maximum recovery in the early months to years of life. Such a patient would have enough voluntary motor power to ambulate but because of functional limitations related to spasticity, is hampered by the need for assistive devices (braces, walkers, etc.). The child may even be losing ground in therapy or be developing progressive contractures related to spasticity. The ideal patient should have sufficient cognitive ability and motivation that he can participate in aggressive rehabilitative efforts. Children of three to six years of age are ideal, but teenagers can also expect good results. A trial of medical management for spasticity with baclofen or other muscle relaxants is recommended prior to consideration of surgery. The response to medication in terms of reduction of muscle tone and alteration of performance ability may prove helpful in the presurgical selection process. In certain instances severely handicapped patients, such as the spastic tetraplegic in whom spasticity is painful or interferes with effective nursing care, can be considered for the procedure.

Certain contraindications of selective posterior rhizotomy have evolved. Patients having progressive encephalopathies in whom continued deterioration in neurologic function is expected, should not be considered for the surgical treatment of spasticity. Another adverse neurologic abnor-

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mality from the standpoint of success of rhizotomy is choreo-athetosis. The same holds true for a cerebellar ataxia related to the cerebral palsy. Both of these conditions may be made worse by rhizotomy, and such patients are excluded in the screening process. Profound weakness is another contraindication to surgery. Certain children have intrinsically weak lower extremity muscles and make use of their spasticity of maintain joint stability. In such cases, relief of spasticity may leave them no longer able to stand. A quick and simple screening test for this is to have the patient perform deep knee bends and straighten up from the squatting position. The ability to do this indicates that the patient has sufficient intrinsic muscle strength for rhizotomy. Patients who have had previous orthopedic procedures such as tendon releasing or muscle lengthening procedures will also be excluded if the orthopedic procedure compromises motor power significantly. For this reason, most centers now suggest that children with cerebral palsy be considered for dorsal rhizotomy prior to performing any orthopedic procedures. Because the procedure carries with it the risks attendant to major spinal surgery, patients having minimal spasticity or those who respond well to medications may be better treated in other ways.

Finally, the success of selective dorsal rhizotomy de-



Figure 1. Intraoperative photograph shows surgeon using microscope and fine stimulating electrodes for dissection of nerve rootlets.

pends in part on rehabilitative efforts requiring the cooperative efforts of the patient and family. Accordingly, severe mental retardation is generally considered a contraindication of surgery. Only in cases in which a reduction in spasticity would assist in nursing care (allowing the patient to bend into the sitting position for wheelchair travel or toilet use) would such children be considered.

In our program, potential candidates for selective posterior rhizotomy are evaluated independently by Pediatric Neurology, Pediatric Neurosurgery, Social Services, Occu-

pational Therapy, Physical Therapy, Pediatric Physiatry, and Pediatric Orthopedics. After a patient has been considered for the procedure, not only is the operation itself explained carefully to the patient and family, but also the requirement for ongoing rehabilitative efforts must be accepted as a commitment to appreciate the success of the procedure. Pre-operative videotaping, emphasizing the patient's posture and

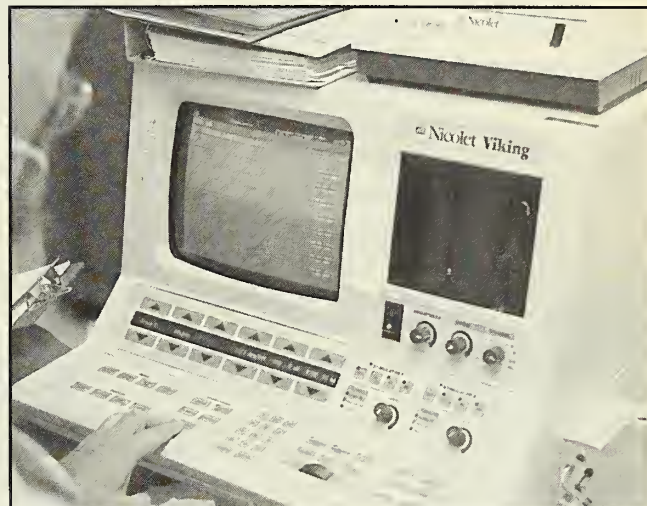


Figure 2. Intraoperative photograph shows electrophysiologist and equipment for recording individual muscle responses to nerve rootlet stimulation.

locomotive abilities, is obtained. Other parameters for objective analysis of the results of selective posterior rhizotomy are being developed, chiefly in the area of computerized gait analysis. Such measurements, as well as the general medical condition of the patient, are all considered prior to selection of the candidates for the surgical procedure.

Operative Procedure

General anesthesia without continuous muscle relaxation is used for the surgery. If patients were taking anti-spasticity drugs prior to surgery, these are discontinued two days prior to the operation. After the patient is anesthetized, EMG electrodes are placed into each of the major muscle groups of the lower extremities. Draping is accomplished so that the neurologist will have visual access to the lower extremities during the stimulation procedures. A standard lumbar laminectomy approach is used, with removal of the laminae from L1 to S1. As a rule, a laminotomy is preformed with a high speed cutting tool to minimize bleeding and to allow replacement of the laminar arches upon completion of the procedure. After opening the dura, each root of the cauda equina is identified and, using microsurgical dissection, the individual rootlets are separated (Figure 1) and stimulated using microsurgical dissection electrodes. The motor root at each level is identified visually and by electrical stimulation. The motor root is then protected while the sensory rootlets stimulated. The electromyographic responses to sensory

root stimulation are then recorded (Figure 2). If a rootlet produces a massive discharge in ipsilateral muscle groups beyond the groups normally innervated by that particular spinal segment and/or produces a discharge from contralateral muscle groups, the rootlet is divided. Careful attention is taken to preserve the blood supply to the conus medullaris traveling through the individual roots. The procedure is repeated for the L2 through S2 rootlets bilaterally. As a general rule, no more than 75% of the sensory rootlets are cut. For the first 48 hours post-operatively, pain and dysesthesias are treated with the liberal use of analgesics to minimize patient discomfort.

Discussion of Outcome

Reduction in spasticity is almost uniformly successful. The effects of reduction of the spasticity are assessed primarily in terms of the patient's ability to sit and walk. Again, the patient selection is important. Peacock² reported that 39 of 40 patients with spastic diplegia experienced improvement in stability and that 15 of 16 quadriplegics improved in side sitting abilities. Of 14 independent ambulators, 12 experienced increases in stride length, and five of eight dependent ambulators became independent of crutches or walkers. Sophisticated gait analysis should show an increase in stride length, more consistent rates of movement, and better efficiency in walking. It is unrealistic to expect that all of the patients will dramatically be converted to normal ambulators; but significant improvement in ambulation, as well as conversion from non-ambulation, may be expected. With proper selection of patients for the procedure, extremely gratifying results have been appreciated in ours, and other series.

Curiously, we and others have noted improvement in upper extremity spasticity, following the rhizotomy in the lumbar region. An adequate explanation for this has not been forthcoming, but must relate to the overall decrease in sensory input to the central nervous system. Indeed, our second patient had an extremely spastic right upper extremity, in addition to a spastic diparesis. Not only did the child appreciate a decrease in lower extremity spasticity, but also for the first time was able to effectively use both upper extremities.

Another side effect of the procedure, noted by other authors, is that patients having seizure disorders appeared to have more easily controllable seizures following rhizotomy. Although the precise mechanism is not clear, this must relate to overall decrease in sensory input in the brain. Certainly we would not recommend dorsal rhizotomy for the control of seizures, but would accept this potential side effect graciously if it occurred.

With the preservation of at least a few of the sensory roots, sensory loss or hypalgesia is an uncommon complication; when it occurs it is generally confined to the distribution of one nerve root and is usually transient. Immediate post-operative dysesthesias generally resolve within a few days.

Since the lower sacral nerve roots are spared, impair-

ment of bowel or bladder function should not occur. The possibility of interfering with blood supply to the conus medullaris is a theoretical consideration in terms of bowel and bladder function, but with careful attention to the radicular blood vessels, bladder dysfunction should only be a transient phenomenon.

In most cases, our operative approach has included replacement of laminar arches of the lumbar spine, following the rhizotomy procedure. Little is known about the growth characteristics of the replaced bone. Therefore, some surgeons prefer to utilize a total laminectomy. Despite that, the development of post-laminectomy kyphoscoliosis has not occurred. This appears to be related to the level of the laminectomies⁵, since cervical laminectomies in children may not uncommonly result in spinal deformity. In fact, only one patient has been reported who developed progressive spondylolisthesis, but that patient had a congenital defect of the pars intra-articularis.

Certainly an incidence of post-surgical complications such as atelectasis and the like, must be dealt with, but the incidence of such occurrences is not significantly higher than with other procedures performed on this patient population.

Conclusions

1. Selective dorsal rhizotomy is the treatment of choice for achieving a permanent reduction in spasticity related to cerebral palsy.
2. The ideal candidate for this operation is the child who has good intellect and has good intrinsic lower extremity motor power but who is limited in ambulation by spasticity.
3. In children who have weak lower extremities and in whom spasticity serves to assist in standing, the surgery is contraindicated.
4. A multidisciplinary team approach to candidate selection and treatment is emphasized.

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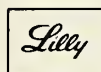
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Prenatal Protocol Usage

Howard P. Parette Jr., Ed.D.*, Ronald K. Brimberry, M.D.,
Jamie Howard, M.D., Gary Woods, M.D., Ronald S. McCord, M.D.**

A review was conducted of 825 obstetrics cases on active computer file at the Department of Family and Community Medicine in Little Rock, Arkansas. Independent raters evaluated faculty and resident usage of a prenatal protocol which was routinely used as a teaching tool in the department's residency program since 1972. Significant differences were found to exist with regard to usage of the tool by physician status. Faculty were more consistent and thorough in their usage of the teaching tool when compared to residents. Differences were explained in terms of a practice effect, research bias of faculty, levels of practice, and potential weaknesses in the educational program.

Introduction

Standardized prenatal risk assessment forms and protocols are routinely employed in medical settings. Usage of such instruments have been claimed to contribute to a reduction in fetal losses and neonatal death rates.¹⁻⁴ At the University of Mississippi Medical Center, for example, use of the Hollister Maternal/Newborn Record System¹ has resulted in a 25% reduction in fetal losses, an 18% reduction in neonatal death rates, and a 21.5% reduction in the perinatal wastage rates reported at that institution.

Conceptually, qualitatively-enhanced care is associated with usage of a prenatal protocol. It provides a systematic, objective means of documenting obstetrical services provided and can be designed to facilitate a collaboration between physicians, nurses, and other professionals involved in the collection of patient information/data. Continuity of care is facilitated due to the maintenance of specific data

throughout the course of each patient's pregnancy. This allows health status comparisons to be made over time.

Use of a protocol may also enhance the medical curriculum of a family practice residency experience since repeated opportunity is provided for use of a teaching tool that is simple yet thorough in its design for the recording of obstetrical data. Theoretically, repeated usage of a protocol culminates in the development of multidimensional observational and clinical skills which has practical implications from a liability perspective in light of increasing obstetrical claims in the United States.² Also, peer review by faculty of resident usage of a protocol is readily facilitated given the comprehensive nature of the data recording format which can be built into such an instrument. This can optimize the opportunity for faculty to cultivate patient management skills among residents.⁵

An instrument designed to aid in the surveillance and management of pregnancies in a family practice residency program should identify and list all problems that require management or follow-up. Residents can be trained to identify problems which will affect perinatal outcome and to enter these on a problem list so that they will not be overlooked.³ Admittedly, no single record form can meet the varying needs of all physicians and hospitals/clinics. Overly simplistic forms which may overlook potential risk factors are no better than difficult-to-manage, sophisticated forms which physicians may never fill out.

This study was initiated to investigate patterns of usage of a prenatal protocol among physicians in a family practice residency program. It was anticipated that differences in usage, both in terms of thoroughness and frequency of usage, might exist as a function of physician experience.

Prenatal Protocol Development

Presented in Figures 1 and 2 are portions of a prenatal protocol which was developed at the University of Arkansas for Medical Sciences, Department of Family and Commu-

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** Drs. Brimberry, Howard, Woods, and McCord are affiliated with the Department of Family and Community Medicine at the University of Arkansas for Medical Sciences in Little Rock.

Figure 1
Prenatal Protocol Checksheet

Each of the following items should be done/discussed at the time indicated (unless asterisked). Each footnote number (or letter over the flow sheet column) has a brief description of rationale and immediate followup instructions if needed. If any item is not done, a rationale should be noted (e.g. "booked too late", "patient refused", or a well argued dissent from the protocol!).

*if indicated

Prior to designing the current version of the protocol, several problematic areas were observed in the obstetrical teaching system employed with residents in the department. Such problems included: 1) differences of opinion among attending physicians regarding the provision of prenatal care due to heterogeneous training backgrounds; 2) time constraints placed on residents in the educational setting which inhibited the opportunity for faculty to provide detailed information to residents at times when such information might be critical for learning; 3) non-receptiveness of residents to a traditional lecture presentation format in the dissemination of prenatal care information in a clinical setting; and 4) the failure of residents to present complete patient histories to attending physicians, or failing to ask appropriate questions to define patient problems in light of time constraints.

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Figure 2
Prenatal Protocol Summary & Flow Sheet

* (U/S¹⁵, HST/OCT²⁰, Herpes²⁶, Group B Strep Evaluation²⁷)

Est of GA⁸: FHT: Dop _____ FHT: Steeth _____ Quickening _____ UMB _____

Problems(all positives) Date Risk(L,AR,H,VM) Problems Date Risk(L,AR,H,VM)

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

*if and when indicated - put date and result

In essence, the format of the protocol differs little from other instruments such as the Hollister Maternal/Newborn Record System, though more preventative issues, e.g., child abuse questions, and educationally relevant issues are reflected in its design.

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and residents regarding usage of the prenatal protocol, a retrospective review was conducted of obstetrical cases at the Family Medical Center from 1972-88. From this review, a total of 825 files were identified by CPT Procedures Codes and/or ICD-9 patient codes on active computer files. These files were examined by three independent reviewers. Patient files were excluded from review if they met one of the following criteria: 1) abortion performed during course of pregnancy; 2) miscarriage or intrauterine demise prior to 28 weeks gestation; 3) referral of the patient to an obstetrician for high-risk obstetrical care, 4) patient relocation; or 5) patient sought care elsewhere after initial booking at clinic. Patients who were subsequently considered for the study were those who were provided prenatal care throughout the course of their pregnancy by either a resident or a faculty member and, in a few cases when needed, also by a high risk

Table 1
Age, Race & Smoking Characteristics
of Patient Populations by Physician Status

Patient Variable	Faculty Patients %	Resident Patients %	p<
Age Class			
14-19	17.9	32.1	.001*
20-24	28.9 (N=173) ^a	36.9 (N=415) ^b	
25-29	27.8	22.9	
30+	25.4	8.1	
Race			
White	66.5 (N=173) ^a	34.8 (N=414) ^b	.001*
Smokers	19.5 (N=169) ^a	29.5 (N=380) ^b	.015*

^a N or patients of faculty members with data available
^b N of patients of residents with data available
* Statistically significant at p<.05

consultant.

A total of 588 cases were appropriate for study based on the aforementioned criteria. Three research assistants served as reviewers of the patient files. These individuals evaluated each patient file, assessing and recording the presence or absence of 50 predetermined items on the protocol. On completion of each assessment, the reviewers rated protocol usage by the faculty member or resident according to the amount of information which had been transcribed to the protocol. Review sheets were then coded and analyzed to examine differences between faculty and resident patient populations, and to determine if there were differences with regard to protocol usage by physician status.

Chi-square analyses were conducted on discontinuous variables, while one-tailed *t*-tests were used to examine continuous variables.

Table 2
Psychosocial Characteristics
of Patient Populations by Physician Status

Patient Variable	Faculty Patients %	Resident Patients %	p<
Psychosocial Problems Present	64.1 (N=167) ^a	74.6 (N=397) ^b	.012*
Marital Discord	7.2 (N=167) ^a	7.3 (N=397) ^b	.910
Unwanted/Unplanned Pregnancy	54.5 (N=167) ^a	70.9 (N=281) ^b	.001*
Feels Unloved	4.2 (N=167) ^a	7.8 (N=396) ^b	.116
History Post-Partum Depression	11.4 (N=167) ^a	6.3 (N=396) ^b	.04*
Other Psychosocial Problems	4.2 (N=167) ^a	7.1 (N=397) ^b	.198

^a N or patients of faculty members with data available
^b N of patients of residents with data available
* Statistically significant at p<.05

Results

Of the 588 cases selected for data analysis, 173 patients were seen by six faculty members during the reporting period. However, the preponderance of these cases (98.3%) was seen by three faculty members who constitute the clinic's Family Birthing Group. The remaining 415 cases were seen by 81 residents, reflecting a mean of approximately five patients per resident during the reporting period.

Table 1 reports age, race, and smoking characteristics of the patient populations under study. Faculty patients were more likely to be white, older, and smoke less than resident patients. Table 2 reports significant differences which existed with regard to certain psychosocial variables. Resident patients exhibited a greater percentage of such problems as well as a greater degree of unwanted/unplanned pregnancies. Faculty patients had past histories of postpartum depression almost twice as often as did those seen by residents.

Table 3 denotes four specific concepts that are emphasized in the family practice residency's curriculum and which are deemed to be of importance with regard to documentation on the prenatal protocol. In addressing the question of whether faculty members record the problem list on the protocol more often than residents, it was found that a significant difference existed. Of those patients seen by faculty, the problem list was employed 95.9% of the time, while it was used less frequently (67.2%) by residents. The utilization of an initial risk classification also reflected a significant difference between faculty and resident recording behaviors. Patients seen by faculty were rated with regard to a risk index approximately 87% of the time, while residents tended to rate their patients in relation to risk considerably

less frequently (46.7%). When an oral glucose tolerance test was performed on obstetrics patients, faculty recorded the results on the protocol with high frequency (95.7%) whereas resident recording of such data was noted with less frequency (81.9%). This, too, reflected a significant difference in protocol usage. Faculty patients, in general, were more likely to have an oral glucose tolerance test performed (79.8%) than were resident patients (61.2%), reflecting a significant difference by physician status.

Finally, in examining the percentage of review obtained from the protocol by reviewers (Table 4), faculty were found to record information on the protocol more frequently than were residents. This subjective rating was based on approximately 50 variables which were reviewed on the prenatal protocol.

Discussion

An important finding to emerge from this retrospective review was that faculty utilization of the prenatal protocol evidenced much more consistency and thoroughness than did resident usage of the tool. Given that faculty members in this residency setting are *role models* for physicians preparing to enter the field of family medicine, it is reasonable to assume that their efficiency in using the prenatal protocol would exceed that of less experienced residents. At the very

Table 3 Curriculum Criterion Variables Recorded/Performed by Physician Status		
Variable	Faculty %	Resident %
Protocol Problem List Recorded	95.9 (N=171)	67.2 (N=406)*
Risk Classification Recorded	87.1 (N=171)	46.7 (N=405)*
Oral Glucose Tolerance Test Performed	79.8 (N=173)	61.2 (N=415)*
Oral Glucose Tolerance Test Recorded	95.7 (N=138)	81.9 (N=254)*

* p < .001

least, the findings are suggestive that a theoretical "practice effect"^{6,7} may operate within this particular residency setting such that faculty physicians, or those who use the protocol with greater frequency, demonstrate greater proficiency in the use of the tool. Thus, greater faculty utilization of the instrument would be indicative of level of experience.

Potential Sources of Bias

It might also be speculated that the faculty's interest in prenatal care and related research might bias faculty physicians toward greater use of the protocol. It may be that

Table 4 Percentage of Review Obtained from Protocol by Physician Status*		
Variable	Faculty %	Resident %
90 - 100% Review	83.7 (N=172)	38.3 (N=413)
74 - 89% Review	14.0	50.9
0 - 74% Review	2.3	10.9

* p < .001

though faculty perceive gestational diabetes screening to be important and emphasize this to residents in their curriculum, residents themselves may not feel such screening to be important. Such a perception may be due to the degree of emphasis placed upon such screening in their medical school training. However, even in light of such influences, faculty *emphasize resident usage* of the protocol with obstetric patients. In this perspective alone, assuming that proper training of residents is provided with regard to usage of the protocol, any items selected from the protocol for evaluation purposes would be valid for markers for examining thoroughness in completion of the form.

Practicality of the Protocol

The consistency with which faculty used the tool demonstrated that it was both practical and usable *for faculty* in a teaching environment. Conversely, for residents the issues of practicality and usability may be more a function of time available for recording information on the prenatal protocol. In this study, time studies of faculty versus resident patient caseloads were not examined and it could be that the amount of time available for charting and recording of information is a function of physician status. If indeed this were the case, perhaps faculty should design the clinical schedules of residents in such a manner that adequate time is provided for charting and recording of protocol information. Once it was demonstrated that adequate time was made available, failure to use the protocol could then be assumed to be a function of some other variable or combination of factors, enabling faculty to scrutinize their curriculum and teaching strategies and make appropriate modifications as warranted. It could very well be then that lower levels of resident usage of the protocol are a reflection of weaknesses in the obstetrical training component of the curriculum. In this medical educational setting, it should also be noted that periodic review of protocol usage is conducted by a highly skilled nurse practitioner on resident obstetric patients, providing faculty with ongoing opportunities to evaluate protocol usage by residents. Any problem or deviation from protocol usage is reported to the family practice obstetrics faculty.

In obstetrics, liability issues have been a growing con-

cern to medical practitioners.⁸⁻¹⁰ Individuals in the field of family practice have not been exempt from the escalating influence of litigation, and there is a trend away from the provision of obstetrical care by family physicians across the country.¹¹ The patient population that has traditionally sought obstetrical care from family physicians may not have access to that care in the future if such trends continue. Thus, a tremendous challenge presents itself to Family Medicine if obstetrical care is to survive. Numerous authorities have suggested that practitioners must focus on enhanced prenatal care provided to patients to minimize the potential for liability.¹⁰⁻¹²

If obstetrical training continues to be an integral part of family practice residency programs in the future, increasing utilization of such objective teaching tools as the one reported here may be employed to minimize the liability of practicing family physicians. Residents, in particular, should be provided with ample opportunities to develop competencies necessary to ensure the provision of optimal prenatal care with their patients. The educational challenge presented here is an immense one, and it is recommended that educators give careful thought to the development of necessary obstetrical competencies with the aid of objective teaching tools such as the prenatal protocol.

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Fragmented Evaluation

J. Kelley Avery, M.D.*

A 46 year old farmer was seen in his local community hospital complaining of lower midchest and epigastric pain which had begun about two hours after the evening meal. He had not eaten anything not a routine part of his diet and denied having eaten an unusual amount of food. The pain began suddenly but was not severe at the outset. There was some nausea and as the pain escalated in severity, there was some sweating and one episode of vomiting. He was seen and examined by the Emergency Physician who ordered a chest Xray, an EKG, a CBC and urinalysis, all of which were considered to be within normal limits. A narcotic was administered for pain and, at the patients request, he was transferred to the medical center where he had a longstanding relationship with an Internist.

When he arrived at the center, he was seen in the E.R. His regular physician was being covered by an associate who responded promptly to his call and came to the E.R. where he reviewed the history, examination, and laboratory findings from the Community Hospital. The pain had subsided some with the narcotic administered at the other hospital, but the physician was impressed with the fact that with the pain there was some radiation to the upper back and, during the ambulance ride to the center, the patient had told the EMT that the pain seemed to involve the left leg. The patient was under treatment for mild hypertension, which had been satisfactorily controlled on a small dose of propranolol for the past three of four years.

An EKG was repeated and again showed no abnormality. Enzymes were in the normal range and a repeat chest Xray was ordered for the next morning with the specific note to do a CT of the chest if the plain film showed any abnormality. The patient was admitted to the hospital and spent a

fairly comfortable night. The CXR was done the following morning and reported to be normal.

Having been admitted on Sunday evening, the following morning the patient was seen by his regular physician. The patient reviewed his experience with his doctor but stressed that his discomfort was more epigastric and that he seemed to be having some pain on swallowing that morning.

The patient had been treated some ten years previously for a peptic ulcer and had times since that he would be careful about certain foods and take some antacid. The pain became worse by midmorning with marked vomiting. More narcotic was given and his physician asked an associate of his, who was a Gastroenterologist, to examine the patient's upper GI tract.

By the time the endoscopic examination was done, the patient was having severe pain. The Endoscopist commented that he could not advance the scope beyond the mid-esophagus but to that level the esophagus appeared normal. He speculated that his inability to advance the scope could be due to an extraluminal problem. Following this examination, the patient had extreme pain to which the nurses were not as responsive as the family thought they should be and demanded that the nurses summon the attending physician. This was done and a larger dose of narcotic was prescribed in a phone order. The nurses notes commented on the pain being felt in the mid-chest, back, and lower extremities.

On the larger dose of narcotic, the patient dozed some, but whenever conscious, was in severe pain. On that day after admission, the patient was seen by both his regular Internist and the Gastroenterologist. The family made frequent complaints to the staff that the nurses were not attentive to the patient's pain. The usual battery of blood chemistries was normal, and cardiac enzymes were not elevated.

The second night in the hospital the patient's pain was never satisfactorily controlled. The nurses again failed to attend to the complaints of the patient to the satisfaction of the family who urged the charge nurse to call the attending about the severity of the pain.

* Dr. Avery is the chairman of the Loss Prevention Committee of State Volunteer Mutual Insurance Company and medical director of Ambulatory Services at Saint Thomas Hospital, Nashville, Tennessee.

CT of the chest was ordered for the next morning but shortly after midnight, the patient cried out, sat up and collapsed. Resuscitation efforts were attempted but failed. An autopsy revealed a ruptured thoracic aortic aneurysm.

Loss Prevention Comments

It is extremely difficult in this type of case to ferret out the reasons that three extremely fine physicians would not make the diagnosis. The doctor who saw the patient on admission was obviously thinking along the lines of aneurysm. This was reflected in his admitting note that emphasized the back and leg pain and his order of a CT of the chest if the pain film of the chest was abnormal. Since the Xray of the chest the morning after admission was read as normal no CT was done. The request for the Xray did NOT suggest to the Radiologist the suspicion of aneurysm.

When the regular physician saw his patient the morning after admission, the picture presented to him was one that directed his thinking to the GI tract. The Gastroenterologist was directed by the previous history of peptic ulcer and failed to connect the difficulty encountered in the passing of the scope to the possibility of an aneurysm as the reason.

What can we conclude? The admitting physician probably attributed more importance to a negative CXR in assessing the probability of an aneurysm of the thoracic aorta than

was warranted. Indeed, using the CXR as the only indicator, a majority of thoracic aneurysms would be missed. The attending physician accepted the assessment of his associate without enough independent scrutiny. The Gastroenterologist, like the Radiologist had nothing in the request to examine the patient that would have pointed him in the right direction.

Extremely important in this tragic case was the failure of the physicians to appreciate the extreme nature of the pain. The family charged in the lawsuit that the nurses were negligent in not calling the attending on at least two occasions when the pain was not blunted by the narcotic. Perhaps the nurses were not aggressive enough in calling the attending.

The most compelling conclusion in this case that led to a very large settlement, was the fact that the record never indicated that the three involved physicians connected with each other and put together the observations and thoughts that each was in the position to contribute. Progress notes were brief but not absent. Nursing notes were not wonderful, but fairly expressive.

Do you remember the fable of the three blind men and their descriptions of the elephant? When more than one physician is involved in the management of a patient, it is essential that we put our observations and suspicions together or we can be characterized in the same way.

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Tuberculosis and HIV: Addendum

In a recent article from the February 1991 issue of *The Journal of the Arkansas Medical Society*, an unfortunate error in transcription from the intended text was not recognized prior to publication.¹ This error was in the recommendations for treatment of tuberculosis in AIDS patients. As printed, on page 371, at the very top of the page, the sentence that marks the misprint begins...“If there is disseminated disease or central nervous system disease, or if Isoniazide resistance is present, the Pyrazinamide or Ethambutol can be discontinued after the initial two months.”

Obviously, common sense would recognize this recommendation is in error and a sincere apology is offered for this misprint. The submitted manuscript read as follows: “If there is disseminated disease or central nervous system disease, or if Isoniazide resistance is suspected, all four drugs should be administered. Also, Pyridoxine at a dosage of 50mgs a day should be administered along with the Isoniazide. If no Isoniazide resistance is present, the Pyrazinamide or Ethambutol can be discontinued after the initial two months.” Please add this correction to the original article. The remainder of the recommendations are correct. This oversight was facilitated by the author's call to active duty for military service during Operation Desert Storm and adequate review before publication was somewhat hampered.

Continued recognition of transmission of tuberculosis from HIV-positive patients to both HIV-infected and non HIV-infected persons is ongoing and bothersome. A recent publication describes a patient with *Mycobacterium tuberculosis* resistant to Isoniazide, Rifampin, and Ethambutol who was HIV-positive and undergoing treatment at a Residential Substance-Abuse Treatment Facility in Michigan.² Because of continued positive sputum smears even while on the three drug regimen, the local Health Department was contacted and a TB contact investigation was initiated revealing 160 contacts, including patients and staff. Subsequent skin testing determined at least 15 and possibly as many as 31 persons became infected from this index patient. More importantly and concerning, the repeat skin tests at six months after recognition of the problem were only performed in 70 persons or less than 50% of those potentially exposed in the facility. This clearly may represent an underestimation of those persons from that facility that were

or would be true TB converters. The problem is clearly obvious and, again, recognition of this potential for TB infection to others was underestimated or inadvertently overlooked.

Other important information concerning TB and HIV was recently published reviewing the San Francisco experience. Small et. al. analyzed retrospectively 132 patients reported to both the AIDS and TB registries in that city from 1981 to 1988.³ Fifty-two patients received Isoniazide, Rifampin, and Ethambutol for the first two months, another 39 patients received Pyrazinamide in addition to the other three drugs for the initial two months, and only four patients were placed on Isoniazide, Rifampin, and Pyrazinamide for the first two months. The remainder of the patients received only Isoniazide and Rifampin, 13 patients, or other drug regimens, 17 patients. The encouraging information in this review is that these therapies resulted in reported sputum sterilization (clearing of acid-fast organisms) after a median of 10 weeks of treatment. Median survival from the time of TB recognition was 16 months and the reported relapse rate was only 5%. This data indicates that conventional therapy for TB should be adequate unless multi-drug resistance develops, which would be recognized by continued positive sputum smears while on therapy. How much one can apply this information to other HIV patients in other less sophisticated areas of the country remains to be seen. Still the reported result from an infection control standpoint is encouraging.

Complete and extensive guidelines for the prevention of TB in health care settings in which HIV patients are being treated are now available.⁴ This publication was produced by the Centers for Disease Control and can be purchased for \$3.00 each from: Massachusetts Medical Society, CSPO Box 9120, Waltham, MA, 02254-9120.

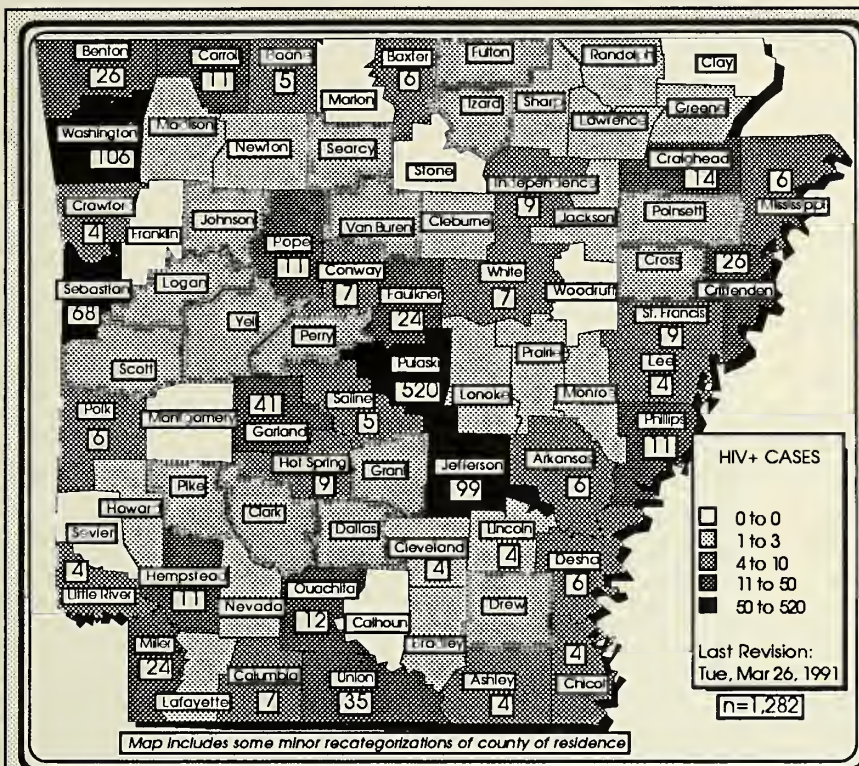
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* Dr. Fournier is associated with the Infection Control Committee at St. Michael Hospital in Texarkana, Arkansas.

Arkansas HIV/AIDS Report

1983-1991



Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statutes 20-15-904, 15-14-123 and 16-82-101.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective responses to the epidemic.

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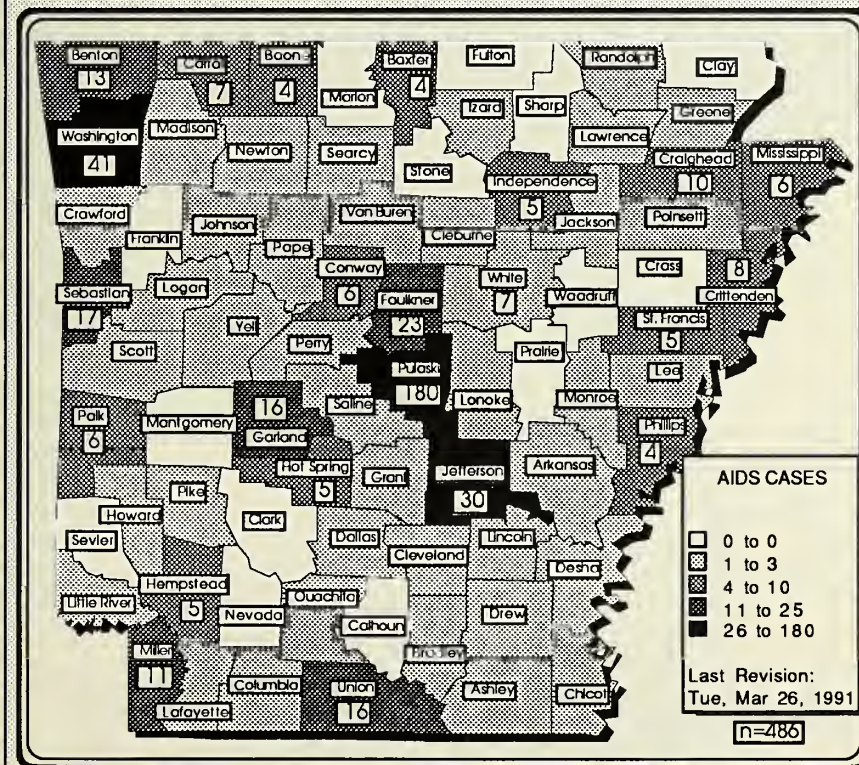
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Nursing Homes

How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes symptomatic, the Surveillance Unit should be updated by form or by phone.

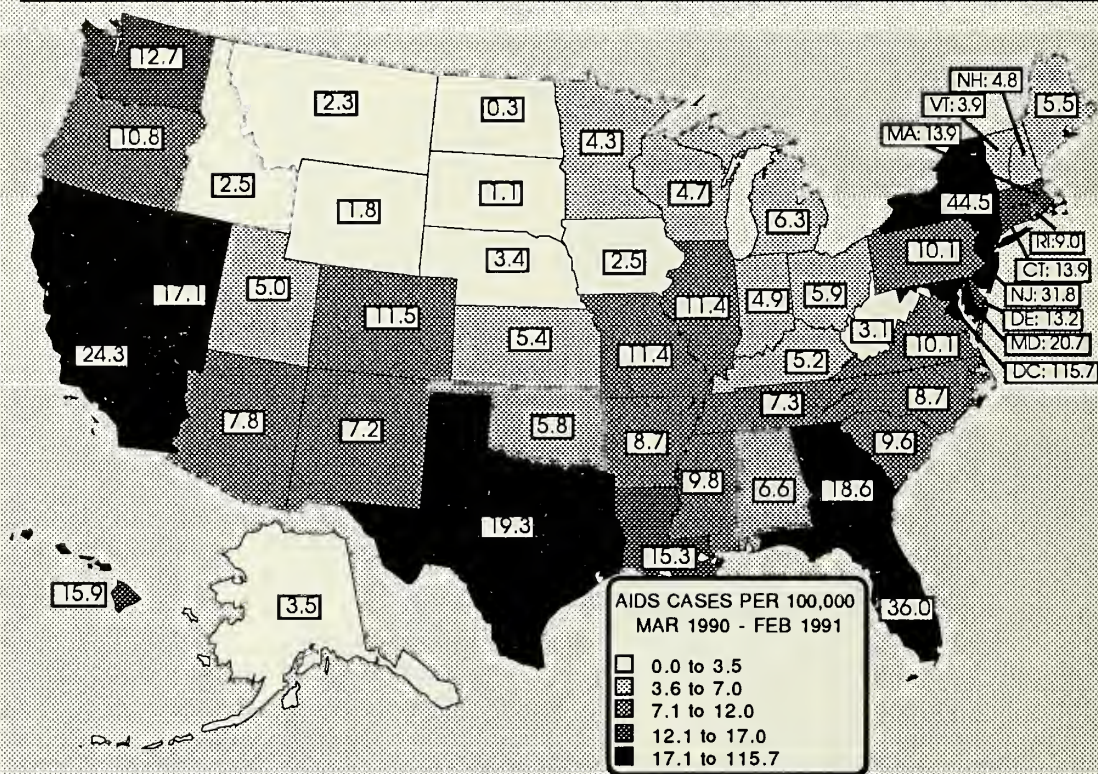
Questions regarding case reporting may be directed to Jan Bunch, AIDS Surveillance Coordinator, 1-501-661-2387.



Arkansas AIDS Report

1983-1991

Arkansas Cases		United States Cases	
Reported: MAR '90 - FEB '91	205	Reported: MAR '90 - FEB '91	42,800
Rates per 100,000 population: MAR '90 - FEB '91	8.7	Rates per 100,000 population: MAR '90 - FEB	17.0
Cumulative Reports: 1983 - MAR '91	486	Cumulative Reports: 1980 - FEB '91	167,803
Adult	474	Adult	164,900
Pediatric	12	Pediatric	2,903
Deaths: 1983 - MAR '91	284	Deaths: 1980 - FEB '91	106,874
Adult	278	Adult	104,874
Pediatric	6	Pediatric	1,487
Mortality Rate	58.4%	Mortality Rate	63.4%



Arkansas Cases by Risk Group		United States Cases by Risk Group	
Gay or Bisexual Men	63.8%	Gay or Bisexual Men	58.2%
Gay or Bisexual Men who used IV Drugs	10.1%	Gay or Bisexual Men who used IV Drugs	6.5%
Heterosexual IV Drug Users	10.1%	Heterosexual IV Drug Users	21.5%
Heterosexual contact with person at risk	5.3%	Heterosexual contact with person at risk	5.3%
Hemophilia	1.6%	Hemophilia	0.9%
Transfusion with blood products	3.9%	Transfusion with blood products	2.4%
Perinatal	1.9%	Perinatal	1.5%
Risk unknown at this time	3.3%	Risk unknown at this time	3.6%

Source: AIDS Surveillance Unit, Arkansas Department of Health.



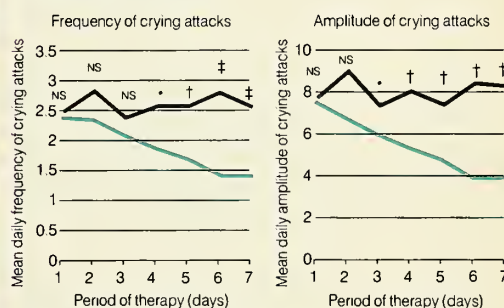
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1. Kanwaljit SS, Jasbir KS. Simethicone in the management of infant colic. *Practitioner*. 1988;232:508.

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AMS Newsmakers

The Baxter County Medical Society recently elected its officers for 1991. They are **Dr. Frederick Turner**, president; **Dr. James Cook**, vice president; and **Dr. Monty Barker**, secretary/treasurer.

Dr. George R. Cole, a Fayetteville obstetrics-gynecology specialist, has been named 1991 chief of the 174-physician medical staff at Washington Regional Medical Center in Fayetteville.

Dr. Thomas R. Dykman, a rheumatologist associated with the Fayetteville Diagnostic Clinic, has been named chairman of the department of medicine at Washington Regional Medical Center in Fayetteville.

Dr. Joycelyn Elders, director of the Arkansas Department of Health, recently received the Nathan David award for her career work as a public servant in the health field. The American Medical Association presented Dr. Elders with this prestigious award.

Dr. Stephen L. Goss, of Bentonville, was elected to fellowship in the American Academy of Family Pediatrics.

Dr. Judy McDonald, an obstetrician-gynecologist associated with the Little Rock Clinic for Women, has been appointed to the health services advisory board with Doctors Hospital in Little Rock.

Dr. Tena Murphy, a cardiologist associated with the Little Rock Cardiology Clinic, has been appointed to the health services advisory board with Doctors Hospital in Little Rock.

Dr. Alvah J. Nelson III, in private practice with Radiation Oncology Associates, has been named chief of staff for Central Arkansas Radiation Therapy Institute.

Dr. Marolyn Speer, a Stuttgart radiologist, has been named to a six-year term on the Stuttgart Memorial Hospital board of directors.

Dr. Rheeta Stecker, a Hot Springs family physician, has been appointed to the position of medical director of St. Joseph's Regional Health Center's new skilled nursing unit. She is president-elect of the Garland County Medical Society.

St. Joseph's Regional Health Center has announced the election of medical staff officers for 1991. They are **Dr. Ron A. Kaler**, president; **Dr. Timothy English**, president-elect; **Dr. Robert V. Borg**, secretary; **Dr. Robert W. Kleinhenz**, chief of surgery; and **Dr. Charles A. Larrison**, chief of medicine.

Dr. I. Dodd Wilson, dean and professor of medicine with the University of Arkansas for Medical Sciences' College of Medicine, has been named a director with the First Commercial Bank, N.A. in Little Rock.

Emergency Medicine: Opportunities are available at client hospitals in Arkansas and Texas. **Hope, Arkansas:** Emergency department medical director and staff opportunities. 75-bed hospital with annual ED volume of 8,000. **Hot Springs, Arkansas:** 3 year old, 150-bed hospital. **Texarkana, Texas:** Full-time ED opportunities at 110-bed facility. Annual ED volume 10,200. Spectrum makes available to independent contract physicians competitive fees, occurrence-based malpractice insurance program, allowance for CME and professional dues, and assistance with relocation expenses. Director also offered health benefits, administrative stipend, and, after 12 months, participation in a 401k plan. For more information, contact Ron Hamilton, Spectrum Emergency Care, PO Box 27352, St. Louis, MO 63141; 1-800-325-3982, ext. 3049.

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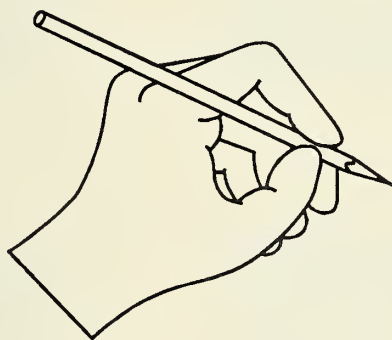
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New Members

BAXTER COUNTY

Barker, Monty R., Otolaryngology, Mountain Home. Born May 6, 1957, Wichita, KS. Medical education, University of Kansas, Kansas City, 1985. Internship, Wesley Medical Center, Wichita, KS, 1986. Residency, Kansas University Medical Center, 1986. Board certified.

CRAIGHEAD/POINSETT COUNTY

Boyd, John T., Internal Medicine, Jonesboro. Born December 6, 1956, Tylertown, MS. Medical education, University of Mississippi School of Medicine, Jackson, 1982. Internship/residency, University Medical Center, Jackson, MS, 1985. Board certified. Practice experience, 5 years.

JACKSON COUNTY

Cole, Barry E., Psychiatry, Newport. Born May 26, 1953, Los Angeles, CA. Medical education, Bowman Gray School of Medicine, Winston-Salem, NC, 1980. Internship/residency, NC Baptist Hospital, 1985. Board certified. Practice experience, 5 years.

MILLER COUNTY

Green, Robert C., Pediatrics, Texarkana, TX. Born April 14, 1960, Texarkana, TX. Medical education, UAMS, 1987. Internship/residency, UAMS, 1990. Board eligible.

Turnage, Richard H., General Surgery, Texarkana, TX. Born September 10, 1957, Lincoln, NE. Medical education, Louisiana State University School of Medicine, Shreveport, 1983. Internship/residency, University of Michigan Medical Center, 1989. Board certified.

PULASKI COUNTY

Davis, Claudia M., Geriatric/Internal Medicine, Little Rock. Born June 2, 1954, St. Louis, MO. Medical education, UAMS, 1982. Internship/residency, UAMS, 1987. Board certified. Practice experience, 4 years.

SEBASTIAN COUNTY

Murphy, Anne L., Pediatrics, Fort Smith. Born January 20, 1959, Little Rock. Medical education, Oklahoma College of Osteopathic Medicine, Tulsa, 1988. Internship, University of Texas at San Antonio, 1989. Practice experience, 1 year.

RESIDENT

Allard, Mark M., Orthopaedics. Born September 1, 19164, Chicago, IL. Medical education, UAMS, 1991. Internship/residency, UAMS.

Baltz, Brad P., Internal Medicine. Born January 26, 1962, El Dorado. Medical education, UAMS, 1988. Internship, UAMS.

Brown, Randel W., Emergency Medicine. Born November 20, 1957, Newport. Medical education, UAMS, 1990. Internship/residency, UAMS.

Callaway, Matthew D., Surgery. Born July 31, 1959, Baton Rouge, LA. Medical education, UAMS, 1989. Residency, Baptist Medical Centers, Birmingham, AL.

Cantwell, Janet S., Pediatrics. Born May 27, 1964, St. Louis, MO. Medical education, UAMS, 1991. Internship/residency, UAMS.

Coalwell, Timothy D. Born November 24, 1951, New Orleans, LA. Medical education, UAMS, 1991. Internship/residency, UAMS.

Cooper Jr., Roy E. Born April 13, 1965. Medical education, UAMS, 1991. Internship/residency, UAMS.

Gordon, Al, Family Practice. Born November 26, 1957, Helena. Medical education, UAMS, 1991. Internship/residency, UAMS AHEC-NW, Fayetteville.

Hale, Jeffrey A., Radiology. Born December 2, 1965, Fayetteville. Medical education, UAMS, 1991. Residency, UAMS.

Hughes, Alan W., Ophthalmology. Born December 3, 1960, Benton. medical education, UAMS, 1990. Internship/residency, UAMS.

Hughes, R. Hal, Internal Medicine. Born March 31, 1965, Benton. Medical education, UAMS, 1991. Internship/residency, UAMS.

Humphreys, James D., Family Practice. Born April 2, 1956, Dumas. Medical education, UAMS, 1988. Internship/residency, UAMS AHEC, Fort Smith.

Kinsinger, John W., Anesthesia. Born May 31, 1962, Oklahoma City, OK. Medical education, University of Oklahoma, Oklahoma City, 1988. Internship, University of Oklahoma, Oklahoma City. Residency, UAMS.

Pickert Curtis B., Pediatrics. Born December 22, 1957, Great Bend, KS. Medical education, University of Kansas, Kansas City, 1991. Residency, University of Kansas. Fellowship, UAMS.

Pippenger, Mark A., Neurology. Born April 26, 1961, Jonesboro. Medical education, UAMS, 1989. Internship/residency, UAMS.

Shaw, Vicky J. Born May 3, 1963, Conway. Medical education, UAMS, 1990. Internship, University Hospital, Clarksburg, WV.

Radiological Case of the Month

David L. Harshfield, M.D.
David W. Bevans Jr., M.D.
Steven R. Nokes, M.D.

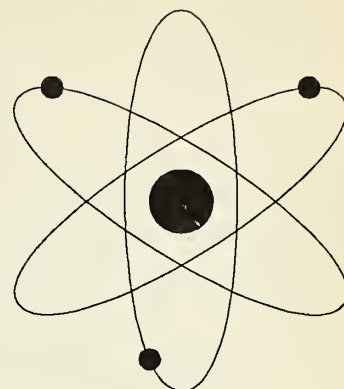


Figure 1. Acute abdomen series.

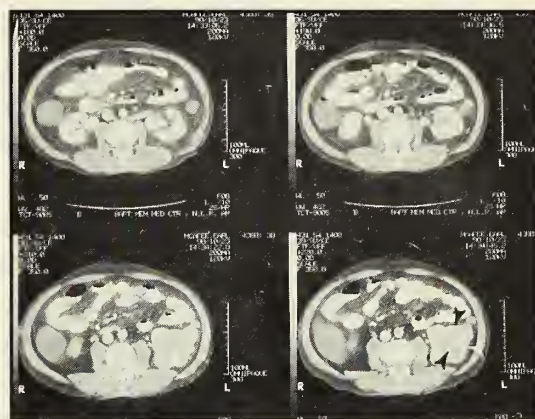


Figure 2. C.T. of abdomen.



Figure 3. Arteriogram left kidney.

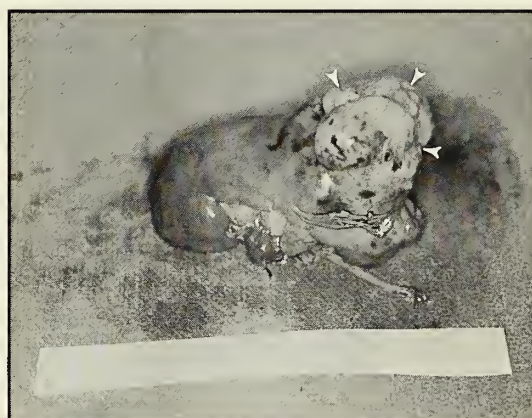


Figure 4. Gross specimen left kidney.

History:

This 60 year-old white male with a 24-48 hour history of epigastric pain, admitted to the emergency room. On physical exam, the patient had generalized abdominal tenderness with pain and cramping, but no focal masses or evidence of peritonitis. Patient had an admitting temperature of 101 degrees F, and a white blood cell count of 10,800 with a left shift. An acute abdomen series was obtained and the results will be discussed.

Renal Cell Carcinoma

Diagnostic Findings:

The acute abdomen series (Figure 1) plain film revealed arc-like stippled calcification (white arrow heads), somewhat irregular in contour, projected over the lower pole of the left kidney. The bones and soft tissues were otherwise unremarkable. After 24 hours, the patient's symptoms improved and his white count returned to 8,000 with the final disposition of the patient's symptoms being secondary to a viral gastroenteritis. The calcification noted incidentally on the acute abdomen series, however, lead to the patient being evaluated for possible renal mass unrelated to his admission symptomatology. A CT scan (Figure 2) was performed, which revealed a predominantly solid mass (white arrow heads) containing calcifications (black arrow heads) in the lower pole of the left kidney. The patient then proceeded to angiography. The angiogram, (Figure 3) in the late arterial-capillary phase, revealed a fairly hypovascular mass with a few large arteries supplying its periphery (white arrow heads). These arteries do not taper normally and there is evidence of encasement and a degree of arterial venous shunting. The gross specimen is shown revealing this lobulated mass emanating from the lower pole of the left kidney (Figure 4, white arrow heads).

Discussion:

Primary malignant tumors of the kidney make up 3% of all human cancer. Renal cell carcinoma accounts for 80% of these tumors. Renal pelvic neoplasms are the next most common, accounting for 10%, followed by Wilms' tumor (or nephroblastoma) making up 5%. Renal cell carcinoma, also called hypernephroma and renal adenocarcinoma, is the most common primary neoplasm of the kidney. It is the third most common malignancy of the urinary tract in men (after prostatic and bladder neoplasms). Renal cell carcinoma is more common in men than in women (3 to 2) and has its highest incidence at ages 50-70, but individuals of all ages can be affected, including children.

It is generally agreed that the tumor arises from the renal tubular epithelium (similarly the most common breast carcinoma arises from the ductal epithelium of the breast). The prognosis is affected most by the presence or absence of capsular invasion and venous extension of the tumor. Metastasis from the renal cell cancers are present at the time of the original examination in from 10-40% of the cases. The lungs are the most common site, with lymph nodes, liver and bones being next most common sites followed by the adrenal, the opposite kidney and the brain.

The radiologic diagnosis can be quite varied, as in this patient, whose lesion was picked up on a plain film finding during an episode of viral gastroenteritis. Calcification is a comparatively common finding in renal carcinoma, occurring in 15-30% of the cases. Calcium deposits occur mainly in areas of hemorrhage or necrosis. Calcifications usually appear in the form of flecks or stippled densities, but occasionally may be linear and/or ring like as in this patient. Very rarely will a benign cyst exhibit this type of calcification. The CT appearance of renal carcinoma is that of a solid lesion producing contour change. This is frequently an irregularly shaped, lobulated or ill-defined margin. In contrast to simple renal cysts, the demarcation between the tumor mass and normal renal parenchyma is usually ill-defined. Although the density of the tumor may be homogeneous, necrosis commonly causes the central part of the tumor to have a low, non-homogeneous CT density, as in this case. Also, intratumoral hemorrhage may cause areas of the tumor to have higher attenuation values if the bleeding has been recent (not seen in this case). Administration of intravenous contrast will accentuate the difference in CT density between normal parenchyma and the tumor. Angiographically, most of these tumors are hypervascular, however, in certain tumor types, such as papillary adenocarcinoma, the tumors are hypovascular. In this particular case, the necrotic, cystic components of the tumor resulted in a somewhat hypovascular appearance. This patient's final pathological diagnosis was well to moderately well differentiated adenocarcinoma of the kidney. There were still, however, the classic findings of irregularly dilated and tortuous vessels probably originating from capsular arteries which hypertrophied to feed the tumor. There was no evidence of venous extension or positive lymph nodes in this case making the patient's prognosis improved.

Contributor: David W. Bevans Jr., M.D., is in private practice and affiliated with Ludwig, Fielder & Bevans Surgical Group in North Little Rock.

Editor: Steven R. Nokes, M.D., is in private practice and is affiliated with Radiology Consultants in Little Rock.

Editor: David Harshfield, M.D., chief of the radiology service at the Veterans Administration Hospital in Little Rock, and head of radiology at Riverside Radiologist Group in North Little Rock.

In Memoriam

Daniel H. Autry, M.D.

Daniel H. Autry, M.D., of Little Rock, died Tuesday, March 19, 1991. He was 82.

Dr. Autry was a retired cardiologist and former chief of staff at St. Vincent Infirmary. He was also a consultant at the Little Rock and North Little Rock Veterans Administration hospitals and the former Army-Navy Hospital in Hot Springs. He was a retired colonel in the Army Reserve and a retired clinical professor at the University of Arkansas College of Medicine, which gave him its Distinguished Service Award.

Dr. Autry was a former president of the Pulaski County Medical Society, the Arkansas affiliate of the American Heart Association and the Visiting Nurses Association; treasurer of the Arkansas Medical Society; board member of the American Red Cross; volunteer consultant to Arkansas Children's Hospital; a fellow of the American College of Physicians; member of the executive committee of American Cancer Society, Pulaski County unit; a member of the American, Southern, and Arkansas Medical Society.

Dr. Autry is survived by his wife, Ellie Powell Autry; two daughters, Ann A. Brown of Corrales, NM and Ellie A. Alderman of Vicksburg, MS; and four grandchildren.

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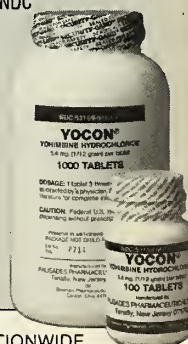
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Resolutions

Keith E. Ashcraft, M.D.

Whereas, the recent death of Keith Edward Ashcraft, M.D., an esteemed member of this Society, is recognized with sincere sorrow; and

Whereas, Dr. Ashcraft was held in high regard by his fellow physicians for his dedication to his profession and specialty; and

Whereas, his concern for the welfare of his patients was widely known; be it therefore

RESOLVED, that this resolution be adopted and placed in the permanent archives of this Society; and

RESOLVED, that a copy of this resolution be sent to Dr. Ashcraft's family as an expression our deepest sympathy; and

RESOLVED, that a copy be sent to *The Journal of the Arkansas Medical Society* for publication.

Adopted
Executive Committee
March 20, 1991

By Order of the Memorials Committee
Marlon J. Doucet, M.D., Chairman
Henry Hollenberg, M.D.
Robert Watson, M.D.



Daniel H. Autry, M.D.

Whereas, the members of the Pulaski County Medical Society note with sorrow the recent passing of one of their esteemed colleagues, Daniel H. Autry, M.D.; and

Whereas, Dr. Autry was a loyal member of this Society for forty-three years, serving as president in 1950; and

Whereas, his untiring service to the American Red Cross, the Arkansas Heart Association, Arkansas Children's Hospital, and numerous other worthy causes exemplified his dedication to the advancement of medicine and the betterment of society; be it therefore

RESOLVED, that this resolution be adopted and placed in the permanent archives of this Society; and

RESOLVED, that a copy of this resolution be sent to Dr. Autry's family as a demonstration of our sincere sympathy; and

RESOLVED, that a copy be mailed to *The Journal of the Arkansas Medical Society* for publication.

Adopted
Executive Committee
March 20, 1991

By Order of the Memorials Committee
Marlon J. Doucet, M.D., Chairman
Henry Hollenberg, M.D.
Robert Watson, M.D.



G. Grimsley Graham, M.D.

Whereas, the members of the Pulaski County Medical Society note with sincere sorrow the recent death one of their esteemed colleagues, G. Grimsley Graham, M.D.; and

Whereas, Dr. Graham served on numerous committees of this Society and was a loyal member for over thirty-five years; and

Whereas, his devotion to God and to his country were evidenced by his service as a deacon of Second Presbyterian Church and as a Marine Veteran and Navy Reservist; be it therefore

RESOLVED, that this resolution be adopted and filed in the permanent records of this Society; and

RESOLVED, that a copy of this resolution be sent to Dr. Graham's family as a token of our heart-felt sympathy; and

RESOLVED, that a copy be made available to *The Journal of the Arkansas Medical Society* for publication.

Adopted
Executive Committee
March 20, 1991

By Order of the Memorials Committee
Marlon J. Doucet, M.D., Chairman
Henry Hollenberg, M.D.
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Medicine in the News

Health Care Access Foundation Update

As of March 1991, the Arkansas Health Care Access Foundation has provided free medical services to 2,673 medically indigent persons.

The program has 1,417 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.

Evaluation of Permanent Impairment

A revised third edition *Guides to the Evaluation of Permanent Impairment* is now available from the AMA. Cost is \$36.00 per copy for AMA members; \$45.00 for non-members. Since its first publication in 1971, this book has become the definitive text on evaluating impairments and is widely used by orthopedic and other surgical specialists as well as by occupational medicine specialists, general practitioners, and physiatrists. Lawyers, state workers' compensation boards and insurance companies all make use of the guides as well. The revised third edition

has several improvements over the original third edition published in 1988. Among them: the section on impairments of the arm and hand is more accurate and understandable and includes new material on finger and hand sensitivity with references. Use of the inclinometer in spinal evaluation is explained and a list of distributors of inclinometers is included. Questions about the book or its use may be directed to Theodore Doege, MD, MS, senior scientist, at the AMA (312) 464-4540.

\$1,000 Research Award Offered

The History of Medicine Associates, an organization created to stimulate interest in the Special Collections Division of the University of Arkansas for Medical Sciences Library, is offering a \$1,000 research award to an individual who is interested in preparing a paper on a aspect of Arkansas medical history. The award is partially funded by grants from the Medical Education Foundation for Arkansas of the Arkansas Medical Society.

Applicants are being sought not only from the health



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sciences, but also history, sociology and health administration, according to Edwina Walls, associate treasurer.

"The 1,000 award is for research in Arkansas medical history on a topic which makes use of the UAMS History of Medicine/Archives collection and other research collections," Ms. Walls explained. "The award may be used at the discretion of the recipient for travel, housing, materials, and research or secretarial assistance."

She stated that a copy of the paper becomes the property of the UAMS Special Collections Division and will be deposited in the UAMS Library. The Associates will assist the author in submitting the paper for publication, but publication cannot be guaranteed.

Applications for the award should include a summary of the paper's topics, a proposed budget and an anticipated completion date. The deadline for applications is May 1991, and the announcement of the recipient will be made the following June.

Applications or questions should be sent to: Edwina Walls, treasurer, Associates, UAMS Library, 4301 W. Markham, Slot 586, Little Rock, Arkansas 72205-7186, or call (501) 686-6733.

Physician Population Increases

America's physician population grew from 260,484 in 1960 to 600,789 in 1989, a jump of 131%, while the total

U.S. population increased by only 36%, according to the latest edition of *Physician Characteristics and Distribution in the U.S.* The result of the accelerated growth in the number of physicians has been an improved physician-to-population ratio. In 1960, there was one physician for every 703 people. In 1989, the ratio was one per 416.

National Practitioner Data Bank Update

The National Practitioner Data Bank (NPDB/Data Bank) issued a statement recently as to how it intends to eliminate delays being experienced in querying.

Since the Data Bank opened on September 1, 1990, it has been receiving more multiple name queries (cadre queries) than had been anticipated, creating delays of eight or more weeks for hospital to receive responses on multiple practitioners. The Data Bank reports that it will clean up the backlog of cadre queries by the end of February, and will thereafter process cadre queries within 20 days of their receipt.

Single-name queries are being given priority because it is assumed that the subject practitioner is being considered for first-time employment, medical staff appointment, or clinical privileges. Responses to single queries are now being processed within five to seven working days of receipt by the Data Bank.

Adverse action and malpractice payment reports are

given priority in processing in order to make the information available to the queriers in a timely fashion.

The Data Bank reports that many hospitals are delaying action on new medical staff applications, renewal of clinical privileges, expansion of privileges, granting of temporary or emergency privileges, and hiring or finalizing a contract until a response to the "Request for Information Disclosure" form(s) has been received from the Data Bank. The Data Bank states that the law (the Health Care Quality Improvement Act of 1986) requires querying, but does not require hospitals and other entities to wait for a response from the Data Bank before proceeding with the granting of privileges, hiring, and/or appointing to the medical staff.

"Health care facilities should consider the Data Bank as one of several resources to be used in the credentials review process, and may act or not act on an application according to whatever criteria they have established and whatever information they have already obtained from other sources," according to the Data Bank.

HCFA Concedes Right to Counsel

HCFA Administrator Gail Wilensky, in a letter to Dr. James Todd, AMA executive vice president, has agreed

with the AMA contention that "during any meeting conducted under the PRO sanction process, a physician should have the right to have, in addition to his/her attorney, a physician counsel present during the entirety of the meeting." The physician counsel would assist the affected physician to present information on medical issues similar to the manner in which the affected physician's attorney assists with legal issues. In the letter received near the start of the year, the HCFA administrator says, "While sanction procedures do not specifically provide for a physician counsel during the above described meeting, nothing prohibits an affected physician from utilizing an expert witness (e.g., a peer physician as a counsel for medical purposes) if he/she wishes. We agree with the AMA in this regard, and also agree that the use of a physician counsel in this manner would not violate any disclosure requirement in regulations." Dr. Wilensky's letter concludes, "Thus, the physician counsel may present expert testimony and answer questions. However, when the PRO begins its deliberations, the PRO representatives are the only people present, as PRO deliberations are protected under the confidentiality regulations. I hope that the information I have provided is helpful to you in addressing the concerns expressed by your colleagues. Thank you for bringing this matter to my attention."

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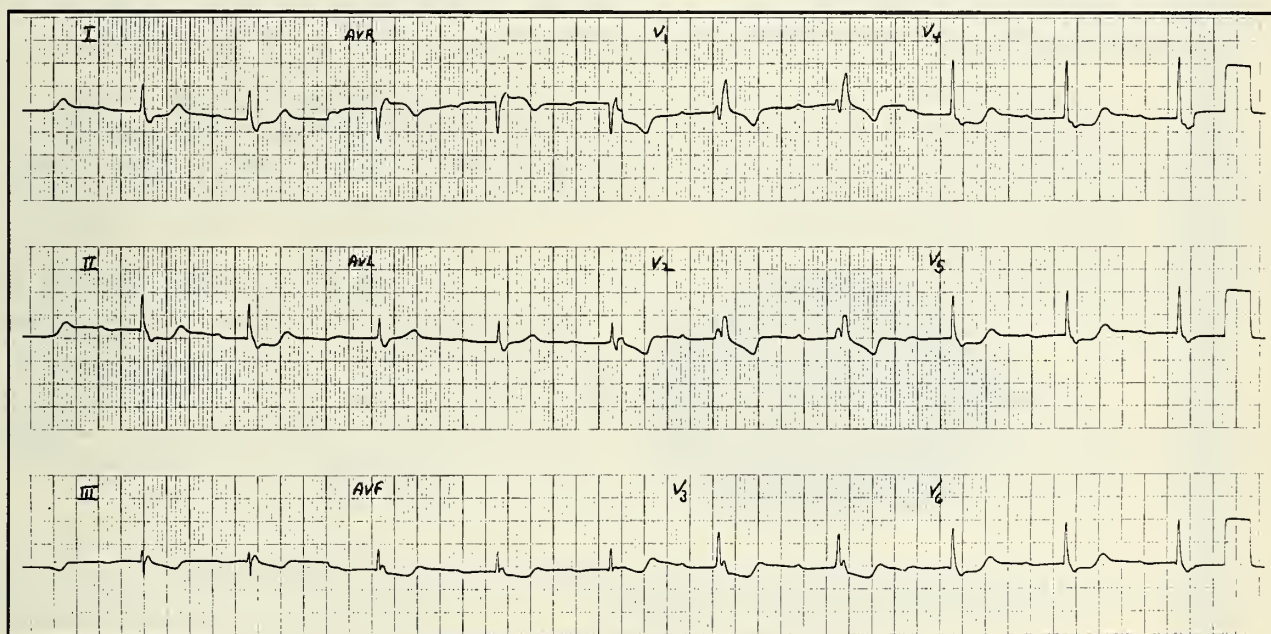


Electrocardiogram of the Month

William C. Furlow, M.D.
John W. Watson, M.D.

CLINICAL HISTORY:

D.L. is a 96-year-old lady who experienced a syncopal episode which resulted in a fractured hip and skull. Her cardiac examination revealed a soft first sound and increased but physiologic splitting of the second heart sound. What do you think of her ECG?



DISCUSSION:

The trace shows sinus rhythm with first degree AV block and right bundle branch block. Additionally, ST depression with a negative slope to the ST segment is noted in the inferior and lateral leads. Ischemia is suggested by the ST change. One could speculate as to the presence of significant impairment of conduction in the His to ventricular portion of the conduction system and give consideration to referral of the patient for electrophysiologic study, especially if no other explanation for syncope is manifested. The auscultatory findings are explicable by the electrocardiographic findings.

The editor wishes to thank Dr. Furlow of Conway, Arkansas, for his assistance with this month's featured electrocardiogram.

Things To Come

May 20-22

Advanced Laparoscopic Surgery. Westin Hotel, Indianapolis, IN. Sponsored by St. Vincent Hospital and Health Care Center, Indianapolis. Fees: \$450.00, physicians; \$350, residents. For more information, call Beth Hartauer at (317) 871-3460.

June 1

Immunologic Aspects of Liver Transplantation. Rush-Presbyterian-St. Luke's Medical Center Inn at University Village, Chicago, IL. Sponsored by the Section of Transplantation Department of General Surgery, Rush-Presbyterian-St. Luke's Medical Center. CME credit applied for. For more information, call 1-800-942-6242.

June 6-8

International Conference on Physician Health. Inn on the Park, Toronto, Ontario, Canada. Sponsored by AMA, Canadian Medical Association, Federation of Medical Licensing Authorities of Canada. CME credit available. For more information, call 1-800-621-8335.

June 6-9

Rhinoplasty Science & Finesse. The Ritz-Carlton Hotel, St. Louis, MO. Sponsored by Washington University School of Medicine. Fees before May 7: \$680.00 physician; \$355.00 physician in training. After May 7: \$730.00 physician; \$500.00 physician in training. CME credits available. For more information, call 1-800-325-9862.

June 9-13

15th Lung Symposium. The Cloister, Sea Island, GA. Sponsored by the Southern Medical Association. For more information, contact LaDonna Nail at 1-800-423-4992.

June 17-19

Breast Cancer Diagnosis: Interventional Procedures. The Westin Resort, Hilton Head, SC. Sponsored by Siemens Medical Systems, Inc. For more information, call Ted Pensiero (908) 906-3807 or Jenny Adamiec (908) 906-3800.

June 28-30

Frontiers in Endosurgery. Washington University Medical Center, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862.

July 20-27

9th Annual Medical Seminar. Plummer's Great Slave Lake Lodge, Northwest Territories, Canada. Sponsored by North Memorial Medical Center and the University of Minnesota Department of Family Practice and St. John's Regional Health Center. CME Category I available. For more information, call (612) 588-9478.

August 1-3

Financial Management Conference. Mariner's Inn, Hilton Head Island, SC. Sponsored by the Medical College of Georgia. For more information, call Donald Murphy or John Norcross at 1-800-221-6437.

October 13-17

Joint Meeting of the American Academy of Ophthalmology and the Pan-American Association of Ophthalmology. Anaheim Convention Center, CA. Sponsored by the American Academy of Ophthalmology. For more information, contact Linda Whitfield, (415) 561-8500.

Physicians' Recognition Award

The Physician's Recognition Award is awarded each month to physicians who have completed acceptable programs of continuing education. The recipients for the month of March are:

William T. Henry
Robert E. Holder
Gregory F. Kresse
John A. Mallory

Little Rock
Bentonville
Eureka Springs
Little Rock

Francis M. Patton
Hon-Kei Poon
Charles P. Sisco
Daniel R. Stevenson

Helena
Newport
Springdale
Jonesboro

MODULATE/DEMULATE

MODEM

EGA CLEARING HOUSE

PC-XT/AT

XENIX

CGA ELECTRONIC CLAIMS SUBMISSION

MEGAHERTZ

RAM

REMOTE ACCESS

VGA

UNIX

ASYNCHRONOUS

MEGABYTES

ROM

ARCNET

SERIAL PORTS

MIPS

HIGH DENSITY

TACTILE HARD DISK

WORKSTATIONS

VGA

9 PIN DOT MATRIX DATA TRANSFER

UNATTENDED POLING CPS

BARCODE RE

DOS PARALLEL INTERFACE

MAGNETIC MEDIA MGA

MONOGRAPHIC ADAPTER

LOCAL PRINTER

AT COMPATIBLE BAUD RATE

WORM DRIVE A-B SWITCH

WEDGE DATA TERMINALS

MULTI-USER ENVIROMNEN

NETWORKING

ACCEPT ASSIGNMEN

CROSSOVER CLAIM

EDS

CHARGE SLIPS HMO WRITE-OFF

CURRENT PROCEDURAL TERMINOLOGY

OUTSIDE LAB CHARGES

SUPERBILL PPO

WORKMAN'S COMP

ICD DIAGNOSIS CODES

REFERRING PHYSICIAN SECONDARY

GROUP NUMBER

PLACE OF SERVICE CODE

HICFA

PRIMARY CARRIER

PRIOR AUTHORIZATION

TYPE OF SERVICE CODES

SAME/SIMILIAR INDICATOR

PATIENT CHARTS DAY SHEETS

SUPERBILL

CPT PROCEDURE CODES

WAITING

LEDGER CARDS

WRITE-OFF

PARTICIPATING PHYSICIAN

ROOM

INSURANCE CARDS

GROUP PLOICY NUMBER

CHARGE SLIPS

MEDICARE

DISABILITY

PATIENT STATEMENTS

RELATIONSHIP TO THE

INSURED

PAYMENT

APPROVED

AMOUNT

TYPEWRITER

APPOINTMENT BOOK

EXAMINATION ROOM

TICKLER FILES

CODING REQUIREMENTS

SELF PAYS

MEDICAID

ATTENDING PHYSICIAN PPO/HMO

DATE OF DISABILITY

DATE OF ACCIDENT

PATIENT RECORDS

RESPONSIBLE PARTY

INDIVIDUAL POLICY NUMBER

ELECTRONIC CLAIMS

STRAIGHT TALK.

SIMPLE SOLUTIONS.

FROM PEOPLE WHO SPEAK

YOUR LANGUAGE.



1-800-628-8274

Keeping Up

Effects of Hypertensive Therapy on Cardiovascular Mortality

May 15, 12:00 noon, Sparks Regional Medical Center. Sponsored by AHEC Fort Smith and presented by Henry Bussey, Pharm.D. Category I credit offered.

Renal Disease in Newborns

May 16, 12:00 noon, Sparks Regional Medical Center. Sponsored by AHEC Fort Smith and presented by Paul Grim, M.D. Category I credit offered.

Pulmonary Complications of Gastroesophageal Reflux Disease

May 21, 7:00 p.m., Education Building, Baxter County Regional Hospital, Mountain Home. Sponsored by Baxter County Regional Hospital and presented by Fred Sutton, M.D. Category I credits offered.

Work-up Dementia/Alzheimer's

May 23, 12:00 noon, Sparks Regional Medical Center. Sponsored by AHEC Fort Smith and presented by Pham Liem, M.D. Category I credit offered.

Basic Electronic Fetal Monitoring

June 7, 7:30 a.m. - 3:30 p.m., UAMS Education II G-137, Little Rock. Jointly sponsored by the Arkansas High Risk Pregnancy Program-UAMS Department of OB/GYN, Arkansas Children's Hospital, The University Hospital, and UAMS Continuing Education for Physicians. Category I credit available. Fees: \$25.00. For more information, call 686-5261.

13th Annual Family Practice Intensive Review

June 7-9, times to be announced, UAMS Education II Bldg. Sponsored by UAMS College of Medicine and presented by Ben Saltzman, M.D. Fee: \$200.00. Credits to be announced.

Infertility Diagnosis and Work-up

June 19, 12:00 noon, Sparks Regional Medical Center. Sponsored by AHEC Fort Smith and presented by Glenn Weitzman, M.D. Category I credit offered.

Organ Donation: A Second Chance for Life

June 18, 7:00 p.m., Education Building, Baxter County Regional Hospital. Sponsored by Baxter County Regional Hospital and presented by George Evanoff, M.D. Category I credits offered.

Advanced Electronic Fetal Monitoring

July 12, 7:30 a.m. - 3:30 p.m., UAMS Education II G-137, Little Rock. Jointly sponsored by the Arkansas High Risk Pregnancy Program-UAMS Department of OB/GYN, Arkansas Children's Hospital, The University Hospital, and UAMS Continuing Education for Physicians. Category I credit available. Fees: \$25.00. For more information, call 686-5261.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

CME Luncheon, second & fourth Friday, 12:30 p.m. AMI Ozark-Quapaw Room. One Category I credit per meeting.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), third Wednesday, 12:30 p.m., conference room, Bldg. 1, VAMC
Medical Grand Rounds, Fridays, 12:00 noon, VAMC

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Alternating Specialty Conference, first Wednesday, 12:00 noon, 2nd floor classroom
Cardiology/Endocrine Conference, third Wednesday, 12:00 noon, 2nd floor classroom

Infectious Disease Conference, second Wednesday, 12:00 noon, 2nd floor classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Auditorium
Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., Sturgis classroom S120-121
Pediatric Research Conference, first Thursday, 12:00 noon, 2nd floor classroom
Pediatric Seminar, first Thursday, 12:00 noon, Sturgis Auditorium

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

Sleep Disorders Case Conference, first & third Thursday, video production conference room. Lunch provided
Interdisciplinary AIDS Conference, second Friday, 12:00 noon. Sandwich buffet served
Cancer Center Team Conference, third Thursday, 12:00 noon, LaHarpe dining room. Lunch provided
Hematology-Oncology Conference, second Thursday, 12:00 noon. Pathology classroom. Lunch provided
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m. Refreshments provided
Pulmonary Conference, second & fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served
Journal Club, Tuesdays, 12:00 noon, Lunch provided
GYN Surgery Cancer Conference, second Monday, 12:00 noon. Southwestern Bell/Arkla room. Lunch provided
Joint Tumor Conference, first Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., conference room 1
GI Conference, fourth Friday, 12:00 noon. Lunch provided
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided
Pathology Conference, first Tuesday, 3:00 p.m., Pathology Library
Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor/BMC. Lunch provided
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided
Sleep Case Conference, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC Oncology Forum, Thursdays, 4:00 p.m., UAMS ACRC 2nd floor boardroom, 1.5 credits
Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Anesthesia Morbidity & Mortality Conference, Tuesdays, 6:45 a.m.; second & fourth Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
Arkansas Blood & Cancer Society Conference, sixth Thursday, 7:30 p.m. Terrace Restaurant, Little Rock
CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy
Cardiothoracic Surgery Conference, date, time, & location varies
Cardiothoracic Surgery Monthly Journals Club, fourth Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Cardiothoracic Surgery Morbidity & Mortality Conference, second Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B
Emergency Medicine Grand Rounds 1, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B
Emergency Medicine Grand Rounds 2, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B
Gastroenterology Grand Rounds, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293
Hematology/Oncology Fellow's Forum, Fridays, 8:15 a.m., ACRC Betsy Blass conference room
LR Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month
LR Vascular Conference, time & date varies monthly, rotates between UAMS, SVI & BMC
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B
Med/Path Conference, third or fourth Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306
Medicine Research Conference, three Wednesdays a month, 4:30 p.m. UAMS Education Bldg. room B/135
Neurology Clinical Case Conference, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH
Neuropathology Conference, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Ob/Gyn Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours
Orthopaedic Basic Science Conference, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours

Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135
Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
Surgery Basic Sciences Conference, first Saturday, 7:30 a.m., ACRC 2nd floor conference room
Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room
Surgery Morbidity & Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room
Surgery Resident Case Conference, second, third, fourth, fifth Saturday, 7:30 a.m., ACRC 2nd floor conference room
Trauma Morbidity & Mortality Conference, date & time varies monthly, ACRC 2nd floor conference room
VA Chest Conference (combined Surgical/Medical Chest Conference), Mondays, 12:15 p.m., VAMC-LR, room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173
VA GRECC/Geriatric Research Conference, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109
VA Hematology/Oncology Conference, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142
VA Lung Cancer Conference, Thursdays, 3:00 p.m., VAMC-LR, room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130
VA Medicine-Pathology Conference, Tuesday, 2:00 p.m., VAMC-LR, room 2D109
VA Medicine Resident's Clinical Case Conference, Fridays, 12:00 noon, VAMC-LR, room 2D08
VA Physical Medicine & Rehab Grand Rounds, fourth Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine Conference, second, third, & fourth Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118
VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology conference room

EL DORADO - AHEC

Behavioral Sciences Conference, first & fourth Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, second Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second & fourth Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, fourth Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, first, second & third Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

Behavioral Sciences Conference, third Wednesday, 12:00 noon, Washington Regional Medical Center
City Hospital Staff Medical Meeting, second Friday, 12:00 noon, Fayetteville City Hospital
Family Medicine Conference, first, third, fourth Thursday; fourth Wednesday; second Thursday (odd months) AHEC-NW
Interesting Case Conference, 1st & 3rd Friday, 12:00 noon, Fayetteville City Hospital
Medicine Conference, first & third Tuesday, 12:00 noon, Washington Regional Medical Center
OB/GYN Conference, June 13, 12:00 noon, AHEC conference room
Pediatric Conference, second Wednesday, 12:00 noon, Washington Regional Medical Center
Radiology Conference, June 5
Surgery Conference, second Tuesday, 12:00 noon, Washington Regional Medical Center Fulbright Board room

FORT SMITH - AHEC

Neuroradiology Conference, third Wednesday, 12:00 noon, St. Edward Mercy Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first & third Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.
Chest Conference, second Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided
Craighead/Poinsett Medical Society, first Tuesday, 7:00 p.m. Jonesboro Country Club
Eaker AFB CME Conference, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria
Independence County Medical Society, second Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, fourth & fifth Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.
Jackson County Medical Society, third Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, third Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, second Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neuroradiology Conference, third Friday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided.
Pocahontas CME Conference, third Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom

Tumor Conference, 2nd Thursday, 4th Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided
Walnut Ridge CME Conference, third & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

PINE BLUFF-AHEC

Behavioral Science Conference, first & third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second & fourth Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, first & fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, second & fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second & fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center
Neuro-Radiology Conference, first & third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

TAKE THE FIRST STEP TO RECOVERY

The Physicians' Health Committee exists for you, the physician who is struggling with drug and/or alcohol addiction. The Committee is composed primarily of physicians who have "been there" and want only to help their colleagues from making the same mistakes.


The Committee members are willing to set up interventions, recommend treatment, and help with after-care and re-entry.

The Committee is not involved in any legal, moral or punitive judgements.

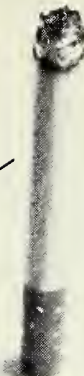
ON CALL FOR YOU

Don't throw away your profession because of drugs and/or alcohol. Contact our Physicians' Confidential Assistance Hotline at (501) 370-8221. Only specially trained personnel will return your call. Or contact the Arkansas Medical Society office (501) 224-8967 or 1-800-542-1058 and ask for the name of one of the Physicians' Health Committee members.


All inquiries are confidential within the Committee and no names or locations are necessary when contacting the Society office.




*"Nah,
I've smoked
for
30 years.
It's too late."*




*"I've tried a
million times,
but I just
can't."*



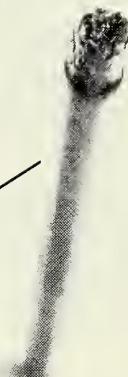
*"I'll
quit
next
week."*




*"I'll quit
next year."*




*"What difference does
it make? I'm already
52 years old."*



*"It's one of the
few pleasures
I have left."*



*"I've got
other things
to worry about."*



*"The damage
is done."*

They know why they can't. Now tell them how they can.

Too many older smokers are still making excuses instead of making a determination to quit. And while most of them know about the more common long term effects of smoking, far too few of them know the facts about the immediate health benefits of quitting.

As a doctor, you can play a unique role in getting your older patients who smoke to quit for good. Take a little extra time and educate your patients about the immediate benefits of quitting. Like a decreased risk of heart attacks and strokes. Improved circulation. And most of all, the years they can add to their lives.

So listen to their reasons for not quitting, then go ahead and give them the facts.

**Let them know:
it's never too late to quit.**

For a free copy of "Clinical Opportunities for Smoking Intervention:
A Guide for the Busy Physician," complete the form below.

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Information Center
4733 Bethesda Avenue, Suite 530, Bethesda, MD 20814
(301) 951-3260**

Name _____

Specialty _____

Address _____

The Journal of the Arkansas Medical Society

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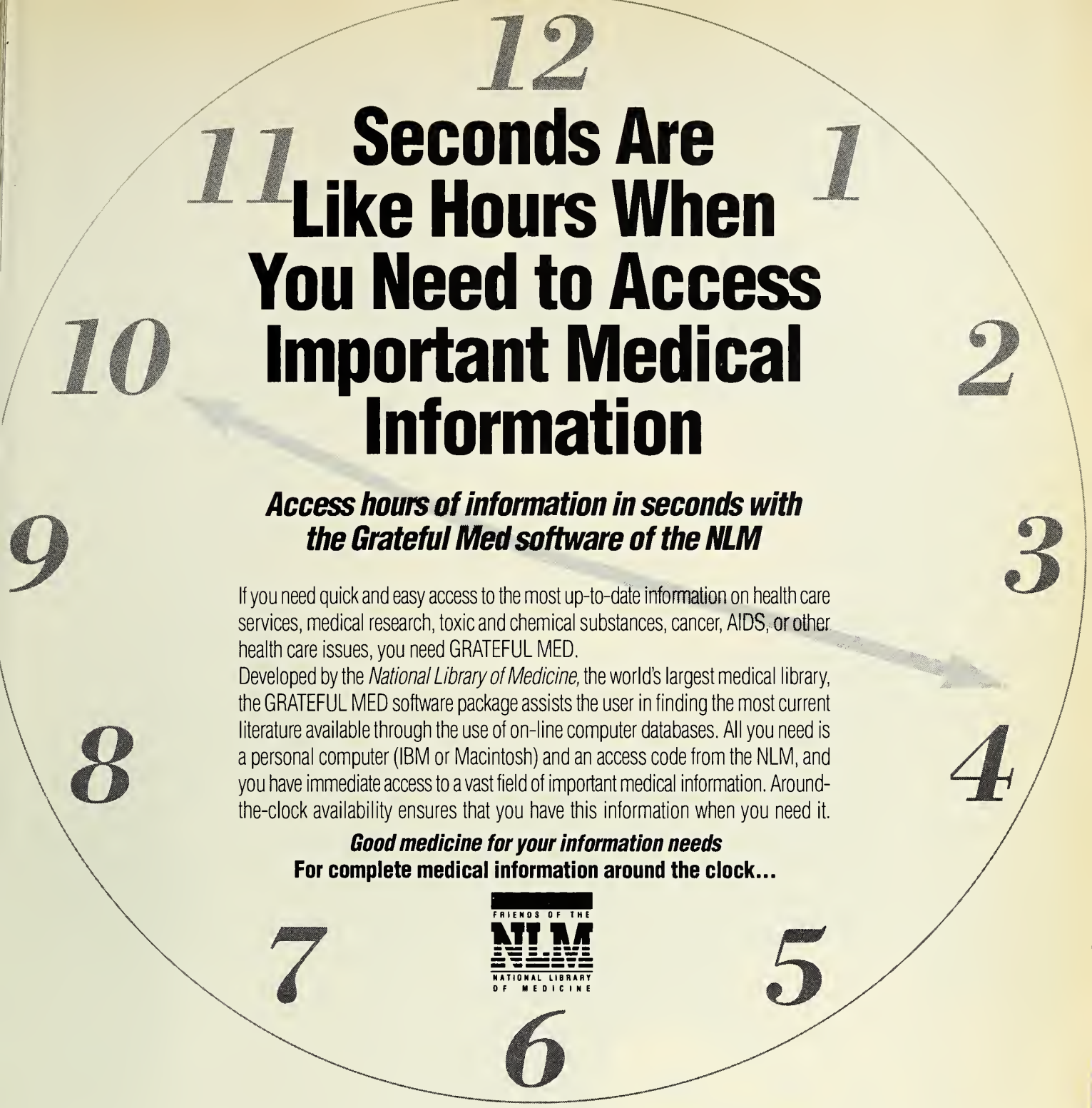


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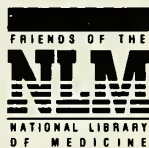
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